Canada. Royal commission on health services.
Hearings, v. 30-32, 1962.

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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

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MEDICAL CONSULTANT:

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DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing
held in Vancouver, B.C.,
22nd day of February, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL ------ Chairman

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SECRETARY:

MR. N. LAFRANCE

--- On commencing at 9.00 a.m.

THE CHAIRMAN: We will proceed this morning with the submission from the Medical Services Association.

THE SECRETARY: Exhibit 165, sir.

---EXHIBIT NO. 165: Submission of the Medical Services Association.

THE CHAIRMAN: Is Dr. McCoy here?

DR. McCOY: Yes.

THE CHAIRMAN: I understand you wanted to file a document, Dr. McCoy?

DR. McCOY: Mr. Chairman, and Commissioners, on Tuesday, when the Canadian Medical Association, B. C. Division were presenting our brief one of the Commissioners referred to the B. C. Medical Journal of May, 1960. We would like to present this exhibit for your information.

THE CHAIRMAN: That will be Exhibit 150C.

---EXHIBIT NO. 150C: B. C. Journal, May, 1960.

SUBMISSION OF

THE MEDICAL SERVICES ASSOCIATION

APPEARANCES:
Mr. A. L. McLellan
Dr. G. Watson
Mr. W. K. McCourt
Mrs. Carruthers
Miss M. Goulick
Dr. J. H. Black
Mr. H. W. Jones
Dr. G. J. A. Kirkpatrick

MR. McLELLAN: Mr. Chairman, I would like to

--- On commencing at 9.00 a.m.

THE CHAIRMAN: We will proceed this morning with the submission from the Medical Services Association.

---EXHIBIT NO. 165: Summation of the Medical Services

THE CHAIRMAN: Is Dr. McCoy here?

DR. McCOY: Yes.

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DR. McCOY: Mr. Chairman, and Commissioners, on Tuesday, when the Canadian Medical Association, B. C. Division were presenting our brief one of the Commissioners referred to the B. C. Medical Journal of May, 1960. We would like to present this exhibit for your information.

THE CHAIRMAN: That will be Exhibit 1500.

---EXHIBIT NO. 1500: 1960.

APPEARANCES:

Mr. A. L. McLellan
Dr. G. Watson
Mr. W. K. McCourt
Miss M. Coulton
Mr. H. W. Jones
Dr. G. I. A. Kirkpatrick

DR. McLELLAN: Mr. Chairman, I would like to

add a word of welcome to you, Miss Girard and the Commissioners. I am sure that all our members would like me to express our appreciation for the interest you are taking. If I may I would like to introduce Dr. Watson, Director of Medical Services, Mr. McCoy who you saw on Tuesday and who prepared the survey which was filed, sir, Miss Goulick, our secretary and Mr. Jones my assistant.

I would like, Mr. Chairman, to read this summary which is very short.

1. Our principal submission is concerned with the development of prepaid medical service plans.

2. We suggest that these systems be helped with technical advice. In particular, consideration should be given to:

(1) Assist financially those people in need. Arrangements could be made with existing agencies to receive contributions and make arrangements for service.

(2) Assist the self supporting with technical advice in dealing with existing agencies or any carriers entering the field.

(3) a. Setting up a special agency, or designating one of the plans as the agent, to cover sub-standard risks who have the means to pay and who have been declined by one of the carriers, supported as a research project by the carriers participating in the programme in proportion to coverage of each plan, and the medical association and underwritten by the doctors or,

Add a word of welcome to you, Miss Girard and the Commissioners. I am sure that all our members would like me to express our appreciation for the interest you are taking. If I may I would like to introduce Dr. Watson, Director of Medical Services, Mr. Mabry who you saw on Tuesday and who prepared the survey which was filed, sir, Miss Gouldick, our secretary and Mr. Jones my assistant.

I would like, Mr. Chairman, to read this summary which is very short.

1. Our principal submission is concerned with the development of proper medical service plans.

2. We suggest that these systems be helped with technical advice. In particular, consideration should be given to:

(1) Assist financially those people in need. Arrangements could be made with existing agencies to receive contributions and make arrangements for service.

(2) Assist the self supporting with technical advice in dealing with existing agencies or any carrier entering the field.

(3) a. Setting up a special agency, or designating one of the plans as the agency, to cover sub-standard risks who have the means to pay and who have been declined by one of the carriers, supported as a reasonable project by the carriers participating in the programme in proportion to coverage of each plan, and the medical association and under-

b. An agency assigning risks on the proportion of coverage to each carrier participating for those persons who have the means to pay but who have been declined coverage by one of the carriers.

Now, Mr. Chairman, we haven't included in our brief the estimate of the cost of our proposal because this estimate is in the brief of the B. C. Division of the C.M.A. and we think it is a working basis. So far the assigned risk plan is proceeding rapidly and no road blocks have appeared on the horizon. (This target, of course, you will realize will be elaborated upon by M.S.I. later on today.) We have had this visit from two of your research staff and we were very happy to co-operate with them. We have here a film which was produced in British Columbia by B.C.M.P., which, I think, if you have the time while you are here or as you go across Canada to see, it might save your staff and yourselves a lot of time because it shows in living colour how this plan operates. Also, could I extend to you, an invitation, if any of your staff are here and want to look at the plan in operation we would be very happy to show it to them.

THE CHAIRMAN: Mr. McLellan, this film that you mentioned, is that something you wish to leave with us?

MR. McLELLAN: Yes, we could.

THE CHAIRMAN: Is that your idea?

MR. McLELLAN: We will show it to you in Toronto or Montreal or anywhere in Canada any time you have half an hour, give us a little time and we would show it to you.

b. An agency assigning rates on the proportion of coverage to each carrier participating for those persons who have the means to pay but who have been declined coverage by one of the carriers.

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MR. McLELLAN: We will show it to you in [illegible]

THE CHAIRMAN: You say half an hour, is the equipment set up?

MR. McLELLAN: We could get it very rapidly for you.

THE CHAIRMAN: I think we will make special arrangements to have it shown on some other occasion, some time when the Commission is together. Mr. Lafrance will be in touch with you regarding having the film available at a time when we have the opportunity to see it.

MR. McLELLAN: We are very proud of it because it was produced in Vancouver, and this is something that doesn't ordinarily happen, for the rest of Canada. Any place you wish to see it we would be very happy if you would take the opportunity.

THE CHAIRMAN: We will take advantage of your offer, but not this morning. Mr. McLellan, in your coverage, roughly what categories do you have?

MR. McLELLAN: Well, we would make a contract with any employer or trustee to cover ten or more employees, ten or 75% of the group participating in the programme. Do you wish me to describe the coverage?

THE CHAIRMAN: You are dealing with groups?

MR. McLELLAN: That is right.

THE CHAIRMAN: Your lowest limit is ten?

MR. McLELLAN: Yes sir.

THE CHAIRMAN: A group of ten, of which 75% will take coverage?

MR. McLELLAN: Ten or 75%, whichever is greater.

THE CHAIRMAN: You say half an hour, is the equipment set up?

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THE CHAIRMAN: A group of ten, of which 75% will take coverage?

MR. McLELLAN: Ten or 75%, whichever is greater.

THE CHAIRMAN: I see, so if it is a group of ten it must be all ten?

MR. McLELLAN: That is right.

THE CHAIRMAN: In that coverage what limitations are there to age?

MR. McLELLAN: None, sir, the only limitation is in respect to children up to age 19. So far as the wife or the employee is concerned there is no age limit.

THE CHAIRMAN: Children over 19 going to school and still dependent might be covered?

MR. McLELLAN: No, not under this programme. There are other means by which they can be covered.

THE CHAIRMAN: What other means?

MR. McLELLAN: If they are going to university they may be covered by M.S.I. The University has a contract with M.S.I. to cover the students.

THE CHAIRMAN: If they are not going to university -- there are many other places you can go for training and education.

MR. McLELLAN: That is true, but so far we haven't any contracts with any of the vocational schools. If any school wished to make such a contract there is no objection to their doing so.

THE CHAIRMAN: On the other end, what happens? Is there any age limit on the senior end?

MR. McLELLAN: No, none for the employee or his wife.

THE CHAIRMAN: What happens when the employee retires or becomes ill or uninsurable?

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THE CHAIRMAN: On the other end, what happens? Is there any age limit on the senior end?

MR. McLELLAN: No, none for the employee or his wife.

THE CHAIRMAN: What happens when the employee retires or becomes ill or unemployable?

MR. McLELLAN: If he retires, a number of employers in the industry have what we call a pension rider to their contract which will allow them to cover their pensioners just the same as when they were employees. If the man is separated from the industry and for other reasons the employer doesn't wish to have the rider, the employee may make an arrangement with M.S.I. to be covered as an individual.

THE CHAIRMAN: With M.S.I.?

MR. McLELLAN: That is right.

THE CHAIRMAN: Not with you?

MR. McLELLAN: If he has been a member of M.S.A. for ten years, ten continuous years, he may be continued by M.S.A.

THE CHAIRMAN: What does the word "may" involve?

MR. McLELLAN: If he applies for coverage within 15 days of leaving the job he may be continued as an individual.

THE CHAIRMAN: Is that the only condition?

MR. McLELLAN: That is right.

THE CHAIRMAN: Regardless of his insurability at that stage?

MR. McLELLAN: No evidence of insurability is required.

THE CHAIRMAN: That would include he and his wife?

MR. McLELLAN: That is right and when he dies his widow may still be continued, and her children, of course.

THE CHAIRMAN: Because you cover groups you are not concerned with insurability?

MR. McLELLAN: No sir, we take the good and the bad. There is so much -- you give insurance and stand the risk that the man will have a wife who is bedridden and so on. There are no restrictions.

THE CHAIRMAN: In time limit, any delay before the policy comes into force at any time?

MR. McLELLAN: No.

THE CHAIRMAN: That is within the group.

MR. McLELLAN: Usually when the plan is established all the employees on the payroll on the day are eligible providing they apply for it. They will be covered on that day. When new employees are hired, depending on the type of industry and what the employer wants to do, there may be a three-month period till they are sure this employee is going to be one of theirs. At the expiration of three months he would be eligible.

THE CHAIRMAN: He becomes a permanent employee?

MR. McLELLAN: That is right, sir.

THE CHAIRMAN: We have a group of 20 and 75% have indicated their desire to join the plan and the other five haven't joined. Could they come in, could they change their mind two or three months or two or three years later and come in?

MR. McLELLAN: There are two methods they could.

THE CHAIRMAN: They elected out in the first place, how can they come in later?

THE CHAIRMAN: Because you cover groups you are not concerned with individuals.

MR. McLELLAN: No sir, we take the good and the bad. There is so much -- you give insurance and stand the risk that the man will have a wife who is bedridden and so on. There are no restrictions.

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THE CHAIRMAN: They elected out in the first place, how can they come in later?

MR. McLELLAN: There are two methods. If the employee suddenly decided he would like to be covered he could submit to a medical examination and providing there is no evidence of uninsurability he would be accepted. Ordinarily we don't like that idea.

THE CHAIRMAN: Whether you like it or not, what happens?

MR. McLELLAN: What happens is what I am about to explain to you, Mr. Chairman, we would go to this employer, and say you have five people here who apparently are not covered, we suggest to you you have a re-canvass and providing we get 75% of those five we will put them on without any evidence.

THE CHAIRMAN: Take all five?

MR. McLELLAN: That is right.

THE CHAIRMAN: If you can't get them, four don't want anything to do with it and there is one fellow who had a change of heart and he would like to join, he must be medically insurable?

MR. McLELLAN: Yes, what would happen in practise, if you run into the situation, which I say is rare, you probably wouldn't refuse that man absolutely, but if there was evidence. . .

THE CHAIRMAN: I am thinking about it from the standpoint of his right.

MR. McLELLAN: Yes, he has the right to be accepted, to submit to a medical examination.

THE CHAIRMAN: What about his wife?

MR. McLELLAN: Yes, wife and family.

THE CHAIRMAN: They have to be medically

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THE CHAIRMAN: What about his wife?

MR. MOLELLAN: [illegible]

THE CHAIRMAN: They have to be medically

examined?

MR. McLELLAN: Yes.

THE CHAIRMAN: If they are not medically insurable that is the end of it?

MR. McLELLAN: No, it would probably be postponed if there were evidence. If he wanted to have all his children's tonsils out, that is the reason he is joining this plan, we would possibly say, let us postpone this for six months. The inference is get this fixed up and you will be accepted.

THE CHAIRMAN: What about the termination, what termination, if any, provisions are there in the contract?

MR. McLELLAN: When the employee leaves the service of the employer his coverage would terminate.

THE CHAIRMAN: When he leaves, let's get it in two stages, voluntarily, just changes his job to get more pay?

MR. McLELLAN: If he goes, his employer under M.S.I. .....

THE CHAIRMAN: If he is going to work for himself?

MR. McLELLAN: Go to work as an individual, as a self-employed person, you mean?

THE CHAIRMAN: That is right.

MR. McLELLAN: Well, so far as M.S.A. is concerned we couldn't do anything for him. We would advise him he could get coverage from M.S.I.

THE CHAIRMAN: He is through as far as you are concerned?

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THE CHAIRMAN: Suppose the termination of employment is involuntary, cut-back in staff or something of that kind?

MR. McLELLAN: That is handled in a variety of ways, mostly informally.

THE CHAIRMAN: What are his rights to retain his coverage?

MR. McLELLAN: He hasn't any rights to retain coverage. The employer has the right to retain coverage for him. If it looks like a temporary thing usually the employer will keep him covered. It is becoming more formalized now. For example, in the lumber industry, which is our chief industry, there is a formal arrangement based on seniority and this man has a right to continue coverage during lay-off.

THE CHAIRMAN: For how long?

MR. McLELLAN: An employee with one year seniority, six months.

THE CHAIRMAN: What happens at the end of the six months?

MR. McLELLAN: The coverage would terminate.

THE CHAIRMAN: And he could go and get coverage from M.S.I. if they would take him on?

MR. McLELLAN: Yes, that is right.

THE CHAIRMAN: What happens in a case of a disability that will require him to cease work or a serious illness or something of that kind where it is neither voluntary quitting of a job or a lay-off, but something else?

MR. McILMILAN: That is right.

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MR. McLELLAN: The employer would keep him covered.

THE CHAIRMAN: The employer, that is out of his generosity, is that what you mean?

MR. McLELLAN: I suppose you could say this.

THE CHAIRMAN: What we are concerned about is the men's right under the contract.

MR. McLELLAN: It is up to the employer whether he keeps the men covered during disability.

THE CHAIRMAN: The man has no right to insist on being covered, to pay his own premium or have someone pay it for him apart from the employer?

MR. McLELLAN: No.

THE CHAIRMAN: Is there any provision for termination of a group contract?

MR. McLELLAN: No, the contracts are written for a year renewable with rates determined by M.S.A.

THE CHAIRMAN: At the end of the year renewable?

MR. McLELLAN: Yes.

THE CHAIRMAN: Is that a right to renew?

MR. McLELLAN: Yes, sir.

THE CHAIRMAN: M.S.A., in the rates of renewal, you can set them higher or lower?

MR. McLELLAN: That is right.

THE CHAIRMAN: What is the control on the increase of the rate, if any?

MR. McLELLAN: The use of service by the group.

THE CHAIRMAN: I mean to say, have you the

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THE CHAIRMAN: I mean to say, have you the

sole arbitrary right to say the premium is increased five times, ten times, twenty times? Could you make it a completely uneconomic rate so that the contract cannot be renewed?

MR. McLELLAN: Well, it is conceivable if somebody is obnoxious enough that we would raise the rate, virtually an invitation out.

THE CHAIRMAN: Raise it high enough.

MR. McLELLAN: Is is the invitation to depart, but I think probably if it became too ....

THE CHAIRMAN: What I want to get at, is there any procedure of arbitration at that stage, some form of determination what is the proper rate, even if they are obnoxious?

MR. McLELLAN: Not any more than the Superintendent of Insurance might exercise some supervision if we became too obnoxious.

hm THE CHAIRMAN: That is just under the same general powers that he has with all insurers?

MR. McLELLAN: If we did not, quite properly, I think, he would take some action.

THE CHAIRMAN: And his action is, of course, a matter of suspension of licence. That is the only way he can really reach an insurer; is it not?

MR. McLELLAN: He has wide powers, and I think he could tell us what to do.

THE CHAIRMAN: He could tell you what to do, but if you do not do it ---

MR. McLELLAN: He could cancel the licence.

THE CHAIRMAN: The only ultimate power he has

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THE CHAIRMAN: He could tell you what to [illegible]

MR. McELLIAN: He could cancel the licence.

THE CHAIRMAN: The only ultimate power he has

is that power of licensing?

MR. McLELLAN: That is true.

COMMISSIONER FIRESTONE: May I ask one belated question. When you come forward and you suggest a higher rate on the occasion of renewal, is your assessment at that higher rate based on the experience of the insurance covered in this group, or is it a community rate?

MR. McLELLAN: No, it is based on the experience of that group, if it is large enough to give you a sufficient idea of what you may expect.

COMMISSIONER FIRESTONE: Well, to come back to the example the Chairman used, a group of 25. You may have a couple of operations in this particular year, and the rate would be abnormally high if you were to use the experience of this particular group. What do you do, sir?

MR. McLELLAN: You would use part of the overall experience of all groups and part of their own experience, and in case of that number of employees, you would probably need the experience of about six years in order to fix a rate.

COMMISSIONER FIRESTONE: But what would you actually do after the year is over and you have found you have paid out more than you collected from this group?

MR. McLELLAN: We would be limited, under our underwriting formula, to how much more we could charge them. We would charge them probably -- supposing that in order to make the thing even, you need 25% more money, we would probably, under the formula, charge 10%.

COMMISSIONER FIRESTONE: What kind of formula

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MR. McLELLAN: That is true.

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COMMISSIONER FIRESTONE: What kind of formula

do you use?

MR. McLELLAN: An established underwriting formula, which is the usual formula by the life insurance companies. It is much the same. You take the experience of the group, if it is large enough, 200, for the previous two years, you see what their experience is there and charge enough money in fixing your rate to recover what losses you had over, say, five years.

COMMISSIONER FIRESTONE: Mr. McLellan, if I may proceed to ask you a few questions relating to the submission you have made, you say in paragraph 3, page 1 of your main submission that your principal submission is concerned with the developing of non-profit prepaid medical service plans. Yours, therefore, is a non-profit plan?

MR. McLELLAN: That is right, sir.

COMMISSIONER FIRESTONE: It is designed to cover the costs of medical services?

MR. McLELLAN: The costs of physicians and surgeons services, yes.

COMMISSIONER FIRESTONE: Now, sir, when you speak of costs of physicians and surgeons services, are we talking of all costs of physicians and surgeons services?

MR. McLELLAN: The personal services of the physician.

COMMISSIONER FIRESTONE: What percentage of fee schedules do you pay the physicians?

MR. McLELLAN: 90% of the official fee schedule.

COMMISSIONER FIRESTONE: Does the physician have any co-insurance or does he make any contribution to

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COMMISSIONER FIRESTONE: Does the physician have any co-insurance or does he make any contribution to

the scheme going, say, below 90%, if you run into a deficit?

MR. McLELLAN: He would, under his contract. As I say, and in our literature it is displayed that the doctors of this province underwrite the plan. For the money we take in, they guarantee that the subscribers will always get the service. If the doctor has to take, say, 85%, that is what he would take.

COMMISSIONER FIRESTONE: But you are starting out in paying maybe 90% and a reduction below the 90% would be based on your operating experience for the year?

MR. McLELLAN: That is true. It has never happened.

COMMISSIONER FIRESTONE: It has never happened?

MR. McLELLAN: No.

COMMISSIONER FIRESTONE: In other words, your premium income less administrative expenses, less reserves, has been adequate to continue to pay 90% of the fee schedule?

MR. McLELLAN: Yes. It was not always 90%, but whatever figure it was, it was what we had agreed to pay.

COMMISSIONER FIRESTONE: Now, sir, what happens if some surgeons wish to charge higher than the accepted fee schedule? Are they free to do so?

MR. McLELLAN: Any doctor may contract himself out of the agreement, providing that before service is provided he arranges that with his patient.

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has to undergo an operation, he is usually referred by his general practitioner to a surgeon and the surgeon then performs the operation, and then presents his bill, and if the bill is more than is covered under your fee schedule --?

MR. McLELLAN: If this surgeon or his nurse, as his agent, has not made any arrangement with that patient or the husband, the surgeon would be obliged to accept the fee paid by M.S.A.

If he endeavoured to collect anyway, we, of course, would refer the thing to the Reference Committee and he would have his day in court.

COMMISSIONER FIRESTONE: Have you had a complaint of this type from some of the subscribers to M.S.A.?

MR. McLELLAN: Yes, there are a few. It is not general. Actually, we have made an extensive study and, as you will realize, there is about 80,000 claims a month and the average complaints for illegitimate extra billing, as we call it, were 113, so we think it is a minimum.

THE CHAIRMAN: 113 a month out of 80,000?

MR. McLELLAN: That is right, sir.

COMMISSIONER FIRESTONE: What happens in those cases of illegitimate claims or billing?

MR. McLELLAN: Well, we would tell the subscriber or his employer that if there were no private arrangement made beforehand with the doctor, they are not obliged to pay. And if in a proper case the doctor persisted, we would offer legal aid to the subscriber, and that usually ends it.

his general practitioner to a surgeon and the surgeon then

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COMMISSIONER FIRESTONE: Now, that is a fair procedure, sir.

Can surgical services --- Well, let us put it differently. Can services of a specialist be employed without referral by a general practitioner, and the payment still be applicable to the fees which a specialist charges?

MR. McLELLAN: Well, for procedural items, and by that I mean surgery, the fee schedule is the same for specialists or general practitioners. Whoever did this extensive operation would be paid the same. Where this problem would arise is with respect to non-procedural items, the consultation. And if this employee went directly to the specialist, which he has a right to do because he has free choice of doctor, then the specialist may, if he wishes, charge the difference to the employee between the general practitioner's schedule and the specialist's schedule.

COMMISSIONER FIRESTONE: Now, if the practitioner -- if the man went to a general practitioner, first, and the practitioner said, "This is really a difficult case; I would suggest you consult this and this specialist", would you then pay the specialist's fee?

MR. McLELLAN: Yes, sir.

COMMISSIONER BALTZAN: In that connection, Professor Firestone, what happens when the individual goes to one of the organized clinics and he probably sees there a general practitioner, and then the general practitioner would want a cardiologist and that group to take a look at him, and the cardiologist might want a neurologist to

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Professor Fitzgerald, what happens when the individual goes to one of the organized clinics and he probably sees there a general practitioner, and then the general practitioner would want a cardiologist and that group to take a look at him, and the cardiologist might want a neurologist to

take a look at him. How does this work?

MR. McLELLAN: If it is a properly referred case within a clinic, the specialist fee would be paid for the consultation.

COMMISSIONER BALTZAN: It could snowball, though? I am not using this in the form of a derision. I am just trying to get at just what happens in cases of that kind.

MR. McLELLAN: Well, there is no evidence that the clinics are not acting properly in these cases.

COMMISSIONER BALTZAN: That was not in my mind.

MR. McLELLAN: We make no difference from a specialist in a clinic and one who may be a lone practitioner. If it is a properly referred case and this man needs specialist attention, it is paid for.

COMMISSIONER FIRESTONE: Do I understand, sir, from what you said a little earlier you would pay the same fee for an operation performed whether the operation be performed by a general practitioner or a specialist?

MR. McLELLAN: Yes. What the schedule fee provides for, yes.

COMMISSIONER FIRESTONE: You will appreciate with the growing specialization, more and more of these operations and surgery is performed by specialists?

MR. McLELLAN: True.

COMMISSIONER FIRESTONE: Still, you only cover what would have cost that particular patient if the operation had been performed by a general practitioner and

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MR. McLELLAN: If I could correct that, Mr. Chairman. The fee schedule item applies to the procedure, not to who did it.

COMMISSIONER McCUTCHEON: If the specialist does it, he is paid the same.

MR. McLELLAN: The general practitioner is not going to operate on your heart; nobody will let him do it. It does not arise.

THE CHAIRMAN: There is no extra-billing at that stage. I think that is what Dr. Firestone is inferring in the question.

COMMISSIONER FIRESTONE: As I understand it, you are paying the specialist and the general practitioner the same amount. Are you suggesting that the fees for the equivalent operation by a specialist in practise is the same as that of a general practitioner, because if that were the case, then there would be no extra-billing, and you are quite right.

MR. McLELLAN: That is right.

COMMISSIONER FIRESTONE: But you are not suggesting that, sir?

MR. McLELLAN: No.

THE CHAIRMAN: I do not think that Mr. McLellan has understood your question.

COMMISSIONER FIRESTONE: The answer, as I heard it, was no.

Can we start again, then, Mr. McLellan.

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If somebody goes to a general practitioner, and the general practitioner says, "You need this operation; it is quite a simple one, and I can do it for you".

MR. McLELLAN: Yes?

COMMISSIONER FIRESTONE: Well, he says, "Doctor, I would prefer a specialist". And the doctor says, "That is fine; I recommend Dr. so and so". And, then, that operation is performed by this specialist.

You would be paying for this operation the fee that is applicable to the operation having been performed by a general practitioner?

MR. McLELLAN: No, we would be paying, according to the item in the fee schedule, which would in effect be a specialist fee.

COMMISSIONER McCUTCHEON: You would be paying the same amount if the general practitioner pulled out the appendix or if the specialist pulled it out?

MR. McLELLAN: That is true.

COMMISSIONER McCUTCHEON: And they both accept it without extra-billing?

MR. McLELLAN: That is right.

COMMISSIONER FIRESTONE: Would you not say the specialist would charge a higher fee, as a rule, than the general practitioner for the same operation?

MR. McLELLAN: No.

COMMISSIONER FIRESTONE: But you are saying that the specialist and the general practitioner are charging the same fee for the same type of work?

MR. McLELLAN: That is true.

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MR. McLELLAN: That is true.

THE CHAIRMAN: It means that they both have

agreed to accept the same fee.

MR. McLELLAN: That is true.

THE CHAIRMAN: That is in your contract?

MR. McLELLAN: That is right.

COMMISSIONER FIRESTONE: If that were the case, there would be no problems with extra-billing, but as I understood there are extra billings.

THE CHAIRMAN: For consultations.

MR. McLELLAN: For consultations is a problem, but for surgery there is no problem, sir.

COMMISSIONER FIRESTONE: As I understood, sir, you have had complaints of people about extra billing. Do any of these complaints include complaints about extra billing for surgical operations?

MR. McLELLAN: No.

COMMISSIONER FIRESTONE: Thank you.

If I may now turn to page 2, you say on the third line that roughly 75% of the people in British Columbia are presently pre-paying all or part of their doctors bills. Now, this refers to various kinds of pre-payment plans that are in existence, and you spell out what these plans are.

What would happen to a person who loses his job; would he still be included under the 75%?

MR. McLELLAN: He may. If he transferred to M.S.I. he would still be in the 75%.

COMMISSIONER FIRESTONE: But if he was covered by M.S.A. and does not transfer to M.S.I because, presumably, at the time he is unemployed, and has less money to pay for the coverage, he would still be included

agreed to accept the same fee.

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MR. McMILLAN: He may. If he transferred to M.S.I. he would still be in the 75%.

COMMISSIONER FIRESTONE: But if he was covered by M.S.A. and does not transfer to M.S.I because currently, at the time he is unemployed, and has less money to pay for the coverage, he would still be included

under the 75% because in this particular year he was covered under M.S.A.?

MR. McLELLAN: At that particular time of the survey, I would say so, yes.

COMMISSIONER FIRESTONE: Paragraph 6 on the same page, sir. You say:

"We submit that only the medical care they "need and not what some demand can in our "economy be provided".

Could you explain to us what you had in mind when you speak of medical care they need; and what you mean by medical care they demand?

MR. McLELLAN: What I mean by that is that I do not see how any plan can operate to pay bills for somebody who goes to see the doctor every Thursday whether they need to see him or not. There is the odd person like that, and that is what I suggest which you, in operating a plan, would need to control such a situation.

COMMISSIONER FIRESTONE: Well, what happens if a person goes in to see the doctor and they say they don't feel well and they ask the doctor to examine them. Is this a case of medical care that person needs or is that medical care that person demands?

MR. McLELLAN: I would say that it is care that he needs.

COMMISSIONER FIRESTONE: Could you give us an example of what you mean by medical care they demand, which is in your opinion not justified?

MR. McLELLAN: Well, an example that was brought to my attention recently was a husband and wife

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MR. McELDRAN: Well, an example that was brought to my attention recently was a husband and wife

who were one of these pensioners who religiously make a visit to the doctor for both of them every month, whether they need it or not. They do not have any particular complaint when they go to the doctor, but they just think it is a good idea if they visit this doctor every month.

COMMISSIONER BALTZAN: Just along that very same line of thought, sir, and the question Dr. Firestone put to you: The question of need versus demand.

Let us say a patient goes into, say, a doctor and he is examined, and the doctor says: "You are all right". And then the patient says, "I came to have my gall bladder x-rayed", or "My chest x-rayed", or "To have an electrocardiogram". The patient says that. Is that what you mean by "demand"?

MR. McLELLAN: Yes, there would be cases like that where medical opinion may be that this is an unnecessary expense. If a doctor needed some support in resisting such a demand, he knows where to get it.

COMMISSIONER FIRESTONE: On page 3, the top of paragraph 6, you say:

"A form of screening by way of authorization "is now in M.S.A. contracts and used when "necessary".

What form does this screening take, sir?

MR. McLELLAN: It has not been necessary to use it directly with patients; but in the odd case it has been necessary to insist that a doctor get prior authorization before procedure; before he performs it, if there has been too many. The Director of Medical Service would suggest a consultation with another doctor he had before he

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proceeds with anything further.

COMMISSIONER FIRESTONE: So, you are exercising a certain amount of control for the practice of medical practitioners through that screening process?

MR. McLELLAN: That is true. Not all these hospitals have organized medical staffs and you may have somebody out in the sticks operating on his own, and some of these fellows come from elsewhere, you know, and come to the promised land and they need to be controlled.

COMMISSIONER FIRESTONE: Is the medical profession prepared to accept that control?

MR. McLELLAN: Yes, sir.

COMMISSIONER FIRESTONE: Now, in paragraph 7, page 3 you refer to:

"Visit to a doctor with irregular pattern
"of practice by medical officers who use
"persuasion in an attempt to have him change
"his ways."

What do you have in mind when you speak of an irregular pattern of practice?

MR. McLELLAN: They would find through a stastical analysis that the doctor has twice as many subsequent visits, for instance, as the average, we would consider that he is calling these people back too often and the medical officer would talk to him about it and attempt to persuade him to do the same as everybody else.

COMMISSIONER FIRESTONE: This is a method of controlling malpractice?

MR. McLELLAN: That is a pretty strong word, malpractice, but it is a method of control or avoiding

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MR. McLELLAN: That is a pretty strong word, malpractice, but it is a method of control or avoiding

wastage.

COMMISSIONER FIRESTONE: And perhaps you would say it is controlling over utilization of the service?

MR. McLELLAN: Yes.

COMMISSIONER FIRESTONE: Do doctors object to this type of control?

MR. McLELLAN: No.

COMMISSIONER McCUTCHEON: Control, of course, is actually exercised by the medical members of M.S.A., the doctors control themselves?

MR. McLELLAN: That is true, yes.

COMMISSIONER McCUTCHEON: If Dr. Watson needed any guidance before he proceeded he would, of course, consult the medical association beforehand so that they are in agreement that it is quite proper to do something about this?

COMMISSIONER FIRESTONE: On the other hand, M.S.A. is not wholly controlled by the medical profession, it has other members as well?

MR. McLELLAN: That is right, sir.

COMMISSIONER FIRESTONE: So it is therefore a joint effort between the medical profession and the lay members?

MR. McLELLAN: That is right.

COMMISSIONER BALTZAN: I would like to ask is the word "control" the proper word or should it be to regulate? It is less than control, it is a matter of internal regulation.

MR. McLELLAN: We do not like one word or

COMMISSIONER FIRESTONE: And perhaps you would say it is controlling over utilization of the

COMMISSIONER FIRESTONE: Do doctors object to this type of control?

MR. McLAELAN: No.

is actually exercised by the medical members of M.S.A., the doctors control themselves?

needed any guidance before he proceeded he would, of course, consult the medical association be'cause as that they are in agreement that it is quite proper to do something about this?

COMMISSIONER FIRESTONE: On the other hand, M.S.A. is not wholly controlled by the medical profession, it has other members as well?

MR. McLAELAN: That is right, sir.

COMMISSIONER FIRESTONE: So it is therefore a joint effort between the medical profession and the M.S.A.

COMMISSIONER BURNAM: I would like to ask is the word "control" the proper word or should it be to regulate? It is less than control, it is a matter of internal regulation.

MR. McLAELAN: We do not like one word or

the other; we try to persuade people to do the right thing. We do not use any big stick or anything like that provided the doctor can understand what it is all about persuasion works.

THE CHAIRMAN: Suppose it does not?

MR. McLELLAN: Then the case is referred to the medical society and they would have him go and use social pressure on him to make a good boy out of him.

THE CHAIRMAN: And if that did not work?

MR. McLELLAN: He would be invited out.

THE CHAIRMAN: Invited out of M.S.A.?

MR. McLELLAN: That is right.

COMMISSIONER FIRESTONE: Or whatever action the medical association may feel appropriate.

THE CHAIRMAN: Well, so far as M.S.A. is concerned that is as far as you go?

MR. McLELLAN: That is true.

COMMISSIONER FIRESTONE: But having reported this to the medical association whatever disciplinary action the medical association takes is up to them?

MR. McLELLAN: That is right, sir.

COMMISSIONER FIRESTONE: Now, how many non-profit medical plans are in existence in the Province of British Columbia?

MR. McLELLAN: Eleven -- do you wish the names?

COMMISSIONER FIRESTONE: No, I just want to follow up this answer by asking, has any consideration been given to amalgamating some of the major voluntary plans?

MR. McLELLAN: No.

the other; we try to persuade people to do the right thing. We do not see any big stick or anything like that provided the doctor can understand - not if he is not persuasion-wise.

THE CHAIRMAN:

MR. McMILLAN: Then the case is referred to the medical society and they would have him go and see

THE CHAIRMAN: And if that did not work

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THE CHAIRMAN: Invited out of M.S.A.?

MR. McMILLAN: That is right.

the medical association may feel appropriate.

THE CHAIRMAN: Well, so far as M.S.A. is concerned that is as far as you go?

COMMISSIONER FLAHERTY: But having recourse this to the medical association whether disciplinary action the medical association hence is up to them.

MR. McMILLAN: That is right, sir.

COMMISSIONER FLAHERTY: Now, not very many profit medical plans are in existence in the province of Saskatchewan Colombia?

MR. McMILLAN: Seven - do you mean the

among?

COMMISSIONER FLAHERTY: No, I just want to

MR. McMILLAN: No

COMMISSIONER FIRESTONE: Would you feel that if a number of these voluntary non-profit organizations were to amalgamate and, therefore, provide a more wide-spread and more rounded and supplementary service to the people of British Columbia that it would provide wider coverage than each group can provide on its own. Secondly, the cost of operating such a scheme might be reduced on a per capita or a subscriber basis.

MR. McLELLAN: If I might answer your question in two directions. A number of these plans that are listed in the brief of the British Columbia Division are what we call closed groups; C.P.R. who cover their own employees, the Telephone Company which covers its own employees, the Provincial Government employees, these are the main ones. Now, these people have started these plans themselves, they are very proud of them and they have a keen interest in operating them and they, I think, do a good job of having their people realize what money they spend is their own. These people are very careful about using that. Unquestionably if they were all amalgamated into one from an administrative point of view we could streamline the thing and cut the administrative expenses; how far we could cut the medical expenses I am not at all sure because I think for the close family unit we would try to encourage that. If we take in the British Columbia Electric we have to be on the ball because it is their plan and as they use it so will the cost be reflected and so on. These people do have an extreme advantage and they do a good job within the limits of the money available.

COMMISSIONER FIRESTONE: Have you given any

[illegible]

[illegible]

people of British Columbia that it would provide wide coverage than each group can provide on its own. Because the cost of operating such a scheme might be reduced on a per capita or a subscriber basis.

MR. MACDONALD: If I might ask a [illegible] question on his direction. A number of these people that are tied to the brief of the British Columbia Division are what we call closed groups; G.E.R. has some their employees, the Telephone Company which covers the [illegible]

the main area. Now, these people have started their [illegible] themselves. They are very proud of what they have [illegible] their interest in operating them and they, I think, do a good job on having their people realize that [illegible] spend in their own. Most people are very [illegible]

[illegible] one from an administrative point of view as [illegible] proceed on the thing and get the administrative [illegible] how far we could go in medical expenses I am not as [illegible] because I think for the close family unit we would [illegible] to make sure that. I we talk in the British Columbia [illegible] we have to be on the best because it is there [illegible] and as they use it so will the cost be reflected [illegible] on. These people do have an extreme advantage and they [illegible] a good job within the limits of the money available.

CHAIRMAN FRASTOR: Have you given any

specific thought to amalgamation between M.S.A. and M.S.I. and from what I gathered you said earlier no thought has been given but would you consider such an amalgamation a desirable thing?

MR. McLELLAN: Well, it is an extremely difficult problem. As you realize, M.S.A. is engaged in writing group coverage and they have never been very keen on individual enrolment because they have not been convinced that a satisfactory contract can be delivered and so M.S.I. was formed with the co-operation of M.S.A. As you realize, the people that operate it are M.S.A. staff and it is a very difficult proposition; the Boards of Directors are voluntary and this is a big proceeding if they are going to engage in individual enrolment and the Board of Directors of M.S.A. can devote the time to all the difficult situations that arise. I think we would have to think about that very seriously because it does take a lot of time and it is a highly experimental proposition. You can often get a group or an employer to talk to or a union but here it would be one individual and probably the only control you would really have is the doctor. M.S.I. has been formed and they are experimenting and continue to experiment and it may be one day that amalgamation may be considered. It has been talked about informally and so on but I think probably it is a little early in the game. If we can get everybody entered in a group arrangement and get this road-block out of the way where people do not have any money to speak of, if they get covered, then I think that we would be well on the way of handling this situation on a community basis where each municipality may handle its

possible thought to amalgamation between M.S.A. and M.S.I. and from what I gathered you said earlier no thought has been given but would you consider such an amalgamation a desirable thing.

MR. HOLMLEY: Well, it is an extremely difficult problem. As you realize, M.S.A. is engaged in writing group coverage and they have never been very keen on individual enrolment because they have not been convinced that a satisfactory contract can be delivered and so M.S.I. was formed with the co-operation of M.S.A. As you realize the people that operate it are M.S.A. staff and it is a very difficult proposition; the Boards of Directors are voluntary and this is a big proceeding if they are going to engage in individual enrolment and the Board of Directors of M.S.A. can devote the time to all the difficult situations that arise. I think we would have to think about that very seriously because it does take a lot of time and it is a highly experimental proposition. You can offer a group or an employer to take 1 or 2 units but then it would be one individual and probably the only contract you would really have is the doctor. M.S.I. has been formed and they are experimenting and continue to experiment and it may be one day that amalgamation may be considered. It has been talked about informally and so on but I think probably it is a little early in the game. If we can, if everybody entered in a group arrangement and get this ground-block out of the way where people do not have any money to speak of, if they get covered, then I think that we could be well on the way of handling this situation on a community basis where each municipality may handle it

own people and then you would have little group enrolments and everybody with the same type of contract if they wanted to buy.

COMMISSIONER FIRESTONE: You really put your finger on a crucial problem. You need an organization to take care of not only those who can pay for this medical care service on a group plan or new basis but the people who cannot afford to pay and they need to change the administration, the staff changes of the operation on an individual basis. To implement such a plan is much more difficult to select one out of several agencies to administer such a plan. For one consolidated group to handle it, that would be much easier for the government to pick the people that have the most experience in the field. There are two reasons and I put it to you in a question whether there are not two reasons for such an amalgamation perhaps sooner than later; one big amalgamated plan will be able to provide services to the people of British Columbia at lower cost, and, secondly, it would be an easier body to administer such a plan as far as contribution for those who cannot afford it are concerned on behalf of a government. Would you feel these two points would be favourable to amalgamation sooner than later?

MR. McLELLAN: I would think, Mr. Chairman, that if a municipality or a city is supplied with funds with which to pay for these people in need that you could leave it to the city fathers to buy what coverage they thought was necessary. Maybe not all the municipalities or cities would want the same type of coverage and maybe a little competition is good for us. I think the cities

COMMISSIONER FRASCTONE: You really put your finger on a crucial problem. You need an organization to take care of not only those who can pay for the [illegible] people who cannot afford to pay and they need to change the administration, the state ownership of the operation on an individual basis. To implement such a plan is much more difficult to achieve one out of several methods to administer such a plan. In one corporation, prior to [illegible] it, that would be much easier for the [illegible] pick the people that have the most experience in the [illegible]. There are two reasons why I put it to you in a [illegible] whether there are not two reasons for such an [illegible] perhaps sooner than later, we may [illegible] [illegible] provide [illegible] the people of [illegible] Columbia or lower costs, and, secondly, it would be a service body to administer such a plan so far as [illegible] for those who cannot afford it are concerned on behalf of a government. Would you feel there is nothing wrong [illegible] favourable to nationalization sooner or later

that is a municipality or a city is supplied with [illegible] with which to pay for those people in need that you [illegible] leave it to the city [illegible] to say what coverage they thought was necessary. Maybe not all the municipalities or cities would want the same type of coverage and maybe a little competition is good for us. I think the other

are now buying coverage for their employees and they have some funds to buy the same type of coverage for those in need and the City Fathers have the machinery and it would be easier for them. They know who these people are and they could probably do a good job of it.

COMMISSIONER FIRESTONE: Are you suggesting that such payments which are made for the medically indigent should be made by the Provincial or the Federal Government to a municipality and the municipality to pay whatever coverage it considers appropriate?

MR. McLELLAN: That is what I suggest, yes.

COMMISSIONER FIRESTONE: To go back to my previous question, would you feel in the light of circumstances as we have described them there is a desirability to consider amalgamation sooner than later? If your view is the time is right for it all you have to say is that is your view.

MR. McLELLAN: I think if you found money to pay for these people in need that this amalgamation could certainly be considered.

COMMISSIONER FIRESTONE: Thank you very much, you have been very helpful.

THE CHAIRMAN: Thank you very much, Mr. McLellan. The next brief is that of the British Columbia Medical Service Incorporated.

THE SECRETARY: That will be Exhibit 166.

---EXHIBIT NO. 166: Submission of B. C. Medical Services Incorporated.

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They such payments which are made in the [illegible] would be made by the Provincial or the Federal Government [illegible] to a municipality and the municipality to pay [illegible]

MR. McLELLAN: That is what I suggest, [illegible]

COMMISSIONER FRANCIS: To go back to [illegible]

[illegible] as we have [illegible] is a general [illegible] to [illegible] [illegible] for [illegible] than [illegible] [illegible] the time is right for it and you have to say in [illegible]

MR. McLELLAN: I think it [illegible]

[illegible] could [illegible] be considered.

COMMISSIONER FRANCIS: Thank you very [illegible] you have been very helpful.

THE CHAIRMAN: Thank you very much, Mr. [illegible]

THE SECRETARY: That will be Exhibit [illegible]

-- EXHIBIT NO. 106: Submission of P. [illegible] Medical Services Incorporated.

SUBMISSION OF

B. C. MEDICAL SERVICES INCORPORATED

APPEARANCES:

Mr. A. L. McLellan
Dr. G. Watson
Mr. W. K. McCourt
Mrs. P. Carruthers
Miss M. Goulick
Dr. J. H. Black
Mr. H. W. Jones
Dr. G.J.A. Kirkpatrick

DR. BLACK: Mr. Chairman, I am here as president and representative of the British Columbia Medical Services Incorporated, a voluntary doctor-sponsored pre-paid medical care plan. My name is Howard Black and I am a physician in the field of general practice in Vancouver. On my immediate left we have Mr. Herbert Jones, executive director of our plan and he has held that position since the inception of the plan some seven or eight years ago. Also representing our plan on my extreme left is Dr. Kirkpatrick, a certified surgeon practising in Vancouver who is our medical director of the plan.

Now, in view of the magnitude of oratorical verbiage that you and your commissioners have been and will be subjected to and out of respect to blood pressures and general nervous system wear and tear I would choose to make no further remarks at this particular time. With your permission I would like to have Mr. Jones very briefly point out to you the highlights of our medical care plan.

THE CHAIRMAN: Thank you, Dr. Black. Mr. Jones?

MR. JONES: I will read the summary:

1. B. C. Medical Services Incorporated (MSI) is pleased

B. C. MEDICAL SERVICES INCORPORATED

PRESENT:

Mr. A. L. Holsinger
Mr. W. M. McCourt
Mrs. P. Cornwallis
Mrs. H. Gourlay
Mr. H. V. Jones

DR. BLACK: Mr. Chairman, I am here as president and representative of the British Columbia Medical Services Incorporated, a voluntary doctor-sponsored prepaid medical care plan. My name is Howard Black and I am a practician in the field of general practice in Vancouver. On my immediate left we have Mr. Herbert Jones, executive director of our plan and he has held that position since the inception of the plan some seven or eight years ago. Also representing our plan on my extreme left is Dr. Kim Pollock, a contracted surgeon practicing in Vancouver and he is our medical director of the plan.

Now, in view of the magnitude of amendments, I would venture that you and your committee members have been and will be subjected to and out of respect to time, I would and general nervous system wear and tear I would choose not to make no further remarks at this particular time. With point out to you the highlights of our medical care plan.

THE CHAIRMAN: Thank you, Dr. Black. Mr.

MR. JONES: I will read the summary:

1. B. C. Medical Services Incorporated (BCMS) is pleased

to appear before and present a Brief to the Royal Commission on Health Services.

2. The MSI Brief confines itself to the provision of Physicians' and Surgeons' services by prepayment.

3. We have not elaborated on the history or growth of prepayment in British Columbia, knowing that at least one other Brief from British Columbia contains these data.

4. 75% of British Columbia's residents are now prepaying their doctor bills through existing carriers.

5. MSI is one of these carriers. It is sponsored by the medical profession of the Province and is designed to care for those risks which cannot be covered by large group plans.

6. The types of medical care plans offered by MSI (8) are designed to meet, and do in fact meet, the demands of those residents of the Province who are not eligible for coverage by large group plans.

7. The 25% of the population not covered by prepaid medical care plans includes 10% of the total population who cannot afford this insurance. To protect them a subsidy would be required.

8. The remaining 15% of the population which is not covered by prepaid medical care is composed in the main of single persons of advanced age, persons engaged in agriculture, persons who for religious reasons do not want medical care, persons whose economic circimstances are markedly depressed, persons such as prospectors and trappers who live remote from settled areas, and a few persons who are

to appear before and present a Brief to the Royal Commission on Health Services.

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3. We have not elaborated on the history or growth of prepayment in British Columbia, knowing that at least one other Brief from British Columbia contains these data.

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The types of medical care plans offered by MSI (8) are designed to meet, and do in fact meet, the demands of these residents of the Province who are not eligible for coverage by large group plans.

The 25% of the population not covered by group medical care plans therefore 1% of the total population who cannot afford this insurance. To protect them a subsidy would be required.

The remaining 15% of the population which is not covered by prepaid medical care is composed in the main of single persons of advanced age, persons engaged in agriculture, persons who for religious reasons do not want medical care, persons among

persons such as prospectors and trappers who live remote from settled areas, and a few persons who are

well enough off to ignore prepaid medical aid entirely.

9. As a result of a survey conducted by Western Surveys-Research Ltd. (sponsored by B. C. Medical Services Incorporated, Medical Services Association, and the B. C. Division, Canadian Medical Association) it was found that the great majority of the population would prefer a free choice of doctor, payment for medical care on a fee-for-service basis, a means test if such should be deemed necessary, and an experience rating in order to assist in controlling utilization of medical care.

Again, Mr. Chairman, I will have to qualify this.

10. To provide medical care coverage for the 15% of total population which is not covered, but which could pay for coverage, a "Pooled Risk" plan has been set up by the officers of all the Approved Plans in the Province, and MSI will be the carrier for the pool. This Plan is specially designed to care for the needs of substandard risks and to spread the cost of meeting their needs among all underwriters.

Page 6 of the text, Mr. Chairman, it was qualified in there, in section 13, by the time the Commission meets in British Columbia it may well be in effect. You will understand from what Mr. McLellan has mentioned earlier this morning this plan isn't actually in effect at the moment. However, it is anticipated that it will be and plans to have it are proceeding. The other

and the B. C. Division, Canadian Medical Association) it was found that the vast majority of the population would prefer a free choice of doctor, payment for medical care on a fee-for-service basis, a means test it such should be deemed necessary, and an experience rating in order to assist in controlling utilization of medical care.

Again, Mr. Chairman, I will have to qualify

10. To provide medical care coverage for the 100,000 total population which is not covered, and which would pay for coverage, a "Pooled Fund" plan has been set up by the officers of all the approved plans in the province, and MCI will be the carrier for the pool. Data from the actuarially designed rates for the people of underdeveloped areas and for approved the cost of medical care, needs more, underwriters.

Page 6 of the text, Mr. Chairman, it was modified in three, in section 13, by the time the consultation meets in British Columbia it may well be

in effect at the moment. However, it is anticipated that will be new plans to have it are proceeding. The other

1 part of Section 10 which is probably misleading, as you
2 may gather that the 15% of the uncovered population with
3 the presumed means to pay would be covered under this
4 plan. That is not the intent. It is our estimate that
5 no more than 3% and probably 1% of the population of British
6 Columbia would require assistance through this pooling
7 arrangement. In other words, these persons are what might
8 be termed substandard risks. The balance, 13, 14% of the
9 people can or could buy from existing carriers and don't
10 require this pooling arrangement to pre-pay their doctors'
11 bills.
12 11. The remaining 10% of the population who cannot
13 afford prepaid medical care will require a subsidy.
14 In Section 14, sections 3 to 10 examples
15 of the type of plan are shown.
16 12. Finally, then, our submission is that promotion
17 of existing voluntary organizations designed to
18 provide medical care, particularly when they are
19 reinforced by an adequate form of pooled risk
20 device, can very effectively provide for all persons
21 who can afford such insurance.
22 THE CHAIRMAN: Thank you, Mr. Jones. Will
23 you explain further the pooled risk device.
24 MR. JONES: Yes, Mr. Chairman. This is not a
25 wholly new idea.
26 THE CHAIRMAN: I take it this is borrowed
27 from the automobile insurance set-up?
28 MR. JONES: That is correct. The idea
29 originate there and it is one that the life underwriters
30 have considered, some such pooling arrangements set up

part of Section 10 which is probably misleading, as you may gather that the 12½ of the uncovered population with the presumed means to pay would be covered under this plan. That is not the intent. It is our estimate that no more than 3% and probably 1% of the population of British Columbia would require assistance through this pooling arrangement. In other words, these persons are what might be termed substandard risks. The balance, 13. 14% of the people can or could buy from existing carriers and don't require this pooling arrangement to pre-pay their doctors' bills.

11. The remaining 10% of the population who cannot afford prepaid medical care will require a subsidy.

In Section 14, sections 2 to 10 examples of the type of plan are shown.

12. Finally then, our submission is that promotion of existing voluntary organizations designed to provide medical care, particularly when they are reinforced by an adequate form of pooled risk device, can very effectively provide for all persons who can afford such insurance.

THE CHAIRMAN: Thank you, Mr. Jones. Will you explain further the pooled risk device.

MR. JONES: Yes, Mr. Chairman. This is not a wholly new idea.

THE CHAIRMAN: I take it this is borrowed from the automobile insurance set-up?

MR. JONES: That is correct. The idea originate there and it is one that the life underwriters have considered. Some such pooling arrangements set up

solely for the purpose of allowing persons who are not acceptable under normal underwriting to be protected. The Committee have been studying and working on this project in British Columbia. In its initial service the discussions have been primarily confined to those proved plans together with the B. C. Division of the Canadian Medical Association. The form it will take is one which all the carriers subscribing to this pooling arrangement will agree to support it financially, proportionate to the premium income that that particular carrier enjoys in the Province, and surpluses that might occur in excess of this amount of money would be underwritten by the doctors in practice. Their representatives on the B. C. Division of the Canadian Medical Association have agreed that in the event exposure being so great that the funds established was depleted in addition to premiums, of course, the doctors in practice would accept proration of their accounts for these people. Does that answer your question, sir?

THE CHAIRMAN: What I was wondering, is when the idea, the basis from which this was borrowed, from the insurance field, from the automobile insurance field, primarily, where substandard risk is some sort of a moral risk, uninsurable, because he is not responsible in the way he operates his car, he shows that he is short of responsibility. When you come to the pooled risk, are you thinking in terms of people who abuse the use of their insurance or those who are substandard medically only?

MR. JONES: We are thinking of those who are substandard medically.

acceptable under normal underwriting to be protected.

The Committee have been studying and working on this project in British Columbia. In its initial service the discussions have been primarily confined to those involved together with the B. C. Division of the Canadian Medical Association. The form it will take in our minds all the original suggestions; to this pooling arrangement will agree to support it financially, proportionate to the premium income that that particular carrier enjoys in the province, and assistance that might occur in excess of this amount of money would be underwritten by the doctors in practice. Their representatives on the B. C. Division of the Canadian Medical Association have agreed that in the event experience being so great that the funds established was depleted in addition to premiums, of course, the doctors in practice would accept proration or their accounts for these people. Does that answer your question, sir?

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are substandard medically.

THE CHAIRMAN: What about the other category, the chap who abuses it?

MR. JONES: Well, Mr. Chairman, if this person is carried by one of the carriers he will not be transferred into this pool just because he has this weakness. This person is the responsibility of whichever carrier he is a member of. They have to look after him. In other words, the intent is not to have the carrier shut off his moral or whatever type of risk they have, they would sooner not have.

THE CHAIRMAN: That is the very idea -- from where this idea started was to insure those who no business insurer would take?

MR. JONES: Yes.

THE CHAIRMAN: So the pooled risk device would apply to individuals only?

MR. JONES: Yes, that is correct, sir.

THE CHAIRMAN: Do you contemplate that the substandard in the group might become part of the pooled risk?

MR. JONES: It is not contemplated that it would. This pooled risk plan will be established solely for the person who cannot buy today from one of the existing underwriting underwriters and that couldn't buy for reasons of either physical stability or possibly for any other reason.

THE CHAIRMAN: Do you not accept there are other reasons why an individual cannot buy, that the moral hazard is one great factor in underwriting?

MR. JONES: In the individual underwriting,

THE CHAIRMAN: What about the other category, the chapitre abusers?

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THE CHAIRMAN: Do you not accept there are other reasons why an individual cannot buy, that the moral hazard is one great factor in underwriting?

MR. JONES: In the individual underwriting,

I am sure it is, sir.

THE CHAIRMAN: You are going to eliminate that completely and say it doesn't count anymore?

MR. JONES: Well, I don't want to get into morals.

THE CHAIRMAN: I want to see what you are proposing. I want to see who you are going to cover.

MR. JONES: The prime requisite will be his ability to pay the premium.

THE CHAIRMAN: If he cannot pay he will come into the 10% population who requires subsidy?

MR. JONES: If it is impossible to pay, yes.

THE CHAIRMAN: What do you mean, impossible?

MR. JONES: I think there are people who wouldn't necessarily fall into the 10% but who would refuse to pay the premium and would lose coverage.

THE CHAIRMAN: What about medically uninsurables within the 10%, are you going to exclude anybody for whom the subsidy might be paid?

MR. JONES: Anyone falling in this category would be eligible for coverage without any exclusion for moral or other reasons.

THE CHAIRMAN: Regardless of physical condition?

MR. JONES: That is right, sir.

THE CHAIRMAN: So that, theoretically, you are able to say you would cover 100% of the population?

MR. JONES: That is the object, sir.

THE CHAIRMAN: Just what is the underwriting

I am sure it is, sir.

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THE CHAIRMAN: What about medically unacceptables within the 10%, are you going to exclude anybody for whom the subsidy might be paid?

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THE CHAIRMAN: So that, theoretically, you are able to say you would cover 100% of the population.

MR. JONES: That is the object, sir.

relationship between the British Columbia Medical Services Incorporated and M.S.A.?

MR. JONES: Well, as was explained they are separate entities, separate Boards of Directors.

THE CHAIRMAN: Is there interlocking in the Boards of Directors?

MR. JONES: No, there is no interlocking. There is not necessarily any interlocking of the Boards of Directors. There is between the Boards an operating agreement that has been entered into to have the staff of M.S.A. administer M.S.I. and there is on the Boards an exchange of one director who sits in without a vote.

THE CHAIRMAN: As an observer?

MR. JONES: That is right.

THE CHAIRMAN: So that from the standpoint of administration the two organizations are in fact, one?

MR. JONES: They are kept entirely separate.

THE CHAIRMAN: Same people do the work?

MR. JONES: No, the M.S.I. staff with the exception of myself and Dr. Kirkpatrick are solely employed in M.S.I. There are no others. M.S.I. personnel devote their whole time to M.S.I.

THE CHAIRMAN: And M.S.A. devote their whole time to M.S.A.?

MR. JONES: With the exception of Dr. Kirkpatrick and myself.

THE CHAIRMAN: If there was the amalgamation Professor Firestone was speaking of would it result in the elimination of any of your administrative staff?

MR. JONES: As far as the administrative

relationship between the British Columbia Medical Services Incorporated and M.S.A.?

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staff, sir, M.S.I., I think, rather than being an entity in itself would be a department of M.S.A. because of the different underwritings and different types of business that it, in fact, has.

THE CHAIRMAN: In the M.S.I contract what provision is there for continuation of contract in the event of loss of employment?

MR. JONES: Well, M.S.I., of course, has two basic types of contract. One a group contract, in which groups less than 10.....

THE CHAIRMAN: You also cover groups?

MR. JONES: Groups from 9, in fact, down to 1, self employed persons are covered.

THE CHAIRMAN: These are groups below 10?

MR. JONES: That is correct, sir. I might mention here this point, that M.S.A. and M.S.I. are so set up that we are not in competition with one another. We are completely complementary. M.S.I. group contract is identical to the M.S.A. both in the form of benefits and in the type of underwriting. A member leaving that group is able to apply for an individual contract in M.S.I. provided he does so within 30 days of leaving the group. We encourage them to do this. It isn't left to them to make the application. A person leaving the group is sent a bill and literature and encouraged to pay it and remain in benefit. There is a provision for continuing coverage.

THE CHAIRMAN: Without any medical examination?

MR. JONES: No medical examination whatsoever, no age limit. I could enlarge a little bit if you are

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THE CHAIRMAN: Well now, an individual has a contract?

MR. JONES: Yes.

THE CHAIRMAN: If for some reason he falls on hard days so far as money is concerned and is not able to pay the premium, his coverage terminates?

MR. JONES: That is correct.

THE CHAIRMAN: When he fails to pay. What about reinstatement after that?

MR. JONES: He is eligible for reinstatement at a later date. We don't check the reason as to why his coverage terminated. Possibly we are in error, but we assume he has terminated because he wanted it to terminate. He can apply for reinstatement subject to medical examination.

THE CHAIRMAN: Medical examination here?

MR. JONES: Yes, at his own expense. He may or may not be reinstated. M.S.I. reserves the right to accept him back or not.

THE CHAIRMAN: So that in the consideration that your organization gives to coverage, have you been able to give any thought to the situation of an individual who ordinarily and from month to month is able to pay his premium but for some reason, unemployment or something is not able to pay, how his coverage might be continued under

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some form of automatic right of reinstatement within a period of six months or so or something of this kind?

MR. JONES: On the individual basis, no. We have given some consideration to it on a group basis, charging a higher premium during his employed period to carry him over the other period. To date, we haven't got any such policy.

THE CHAIRMAN: In looking at this 100% coverage that you and others are trying to seek, where does that individual fall, where is he going to fit into the picture of continuous 100% coverage in one form or another?

MR. JONES: Well, Mr. Chairman, this person who, in fact, hasn't the money to pay presumably will fall into this approximately 10% of our people who are in this position.

THE CHAIRMAN: Are you putting that forward seriously, a person who is temporarily financially embarrassed is going to fall into this 10%?

MR. JONES: Well, we outlined in the brief the position in which through a municipal arrangement it would be possible for the municipality to pay this premium for him, to keep him in benefit and to recover from him at a later date if they are able to on a similar basis to the system used for the hospital premiums in Saskatchewan.

THE CHAIRMAN: What happens if a person has a contract which is paid to the end of March and sometime late in February he incurs a serious illness? For how long will he be covered if he doesn't pay the premium due the first of March?

MR. JONES: For the specific illness that the

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MR. JONES: For the specific illness that

person was suffering from, presumably a condition in which he may be hospitalized, M.S.I. would complete the treatment of that case regardless of the fact that his premium isn't paid.

THE CHAIRMAN: Without time limitation?

MR. JONES: As far as that particular ailment or condition was concerned.

THE CHAIRMAN: If the man went and broke his leg in April that would be another story?

MR. JONES: That is correct, sir.

COMMISSIONER STRACHAN: If that were a life illness would that continue?

MR. JONES: No, Dr. Strachan, there is a limitation in these contracts of a year continuous treatment for any one ailment.

THE CHAIRMAN: I put the question -- perhaps you didn't understand. I said without limitation of time.

COMMISSIONER FIRESTONE: Mr. Jones, do your contracts provide for cancellation?

MR. JONES: The group contract is the same as M.S.A's. There is no provision for cancellation by M.S.I. The individual contract provides, in effect, a monthly renewal without our right to cancel, but just within the rate, of course, which might result in cancellation, yes.

COMMISSIONER FIRESTONE: The majority of your contracts are individual contracts?

MR. JONES: No, approximately one half of our business is in individuals; and the other half is in groups.

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COMMISSIONER FIRESTONE: The Chairman has just made the enquiry what is the smallest group you would cover?

MR. JONES: The self-employed person.

THE CHAIRMAN: Then, what is the difference? Why do you seem to infer a distinction between a group and individual?

MR. JONES: Well, there is a difference between self-employed persons and those who are not employed who are also individuals as far as underwriting goes.

THE CHAIRMAN: Who would be unemployed -- you mean a retired person?

MR. JONES: Well, retired persons or --

COMMISSIONER FIRESTONE: How about the person who is employed, but the employer does not have a group plan?

MR. JONES: At the moment, we have no provision to take care of him, either, on a group plan basis.

COMMISSIONER FIRESTONE: But aren't there a number of firms who do not have group plans?

MR. JONES: Oh, there are, yes.

COMMISSIONER FIRESTONE: And people working in these firms cannot get coverage?

MR. JONES: Not through M.S.I. on an individual basis, no. They come through other approved plans in this Province.

COMMISSIONER FIRESTONE: Why do you discriminate against somebody who is working and you take

MR. LOUNSBERY: The self-employed person.

THE CHAIRMAN: Then, next to the driver and

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COMMISSIONER MILLSTONE: Why do you [illegible]

somebody who is an old age pensioner, or a person who is self-employed. Why do you discriminate against the person who is working, an accepted person working for somebody else, and take in a person who is self-employed?

MR. JONES: It is not our intent to discriminate. It is our intent to encourage them to be covered on a group basis so we can provide them with better contracts at a lower rate.

COMMISSIONER FIRESTONE: But if employees cannot hit management over the head, why do you penalize them?

MR. JONES: It is a good question, but the answer is still the same; we do it to encourage group underwriting.

THE CHAIRMAN: And that is settled policy?

MR. JONES: At the moment, that is the policy, sir.

COMMISSIONER FIRESTONE: May I come back to this cancellation privilege, sir?

Have you exercised that cancellation privilege that you said exists in your contract, say, in the last year?

MR. JONES: Mr. Chairman, I have just consulted with Dr. Kirkpatrick. We have never exercised the cancellation clause. We have had one group in which we raised the rate to a point, where they switched their coverage from comprehensive to our partial plan coverage.

COMMISSIONER FIRESTONE: What were the circumstances that led to this situation?

MR. JONES: In our opinion, over-utilizing

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MR. JONES: Mr. chairman, I have just

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MR. JONES: In our opinion, over-utilizing

the service in a wasteful or unnecessary manner.

COMMISSIONER FIRESTONE: Why did this over-utilization take place? What happened?

DR. KIRKPATRICK: I am not quite sure I understand your question, Dr. Firestone.

COMMISSIONER FIRESTONE: Well, I understood from Mr. Jones' answer that the reason for the re-arrangement in the rate was over-utilization.

My question is what form did this over-utilization take?

DR. KIRKPATRICK: I think I can illustrate it by telling you that one of the services rendered was a night call for a superficial dermatitis. This ordinarily is something that can be seen to in the doctor's office, and the fee is $5.00; and it does not warrant a night call at a feee of $10.00. And the whole patterning of the service rendered to this particular group was along this line.

COMMISSIONER FIRESTONE: Are you suggesting there were too many night calls in this group?

DR. KIRKPATRICK: No, I am suggesting there was no discrimination on the part of the subscriber in the way he used the services that were available.

COMMISSIONER FIRESTONE: Was this a single subscriber or a number of subscribers?

MR. JONES: A number.

COMMISSIONER FIRESTONE: Are you suggesting then, sir, that all these subscribers, or the majority of them, behaved in this irresponsible manner?

DR. KIRKPATRICK: Yes.

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COMMISSIONER FIRESTONE: Was there any explanation as to why -- why one group would behave irresponsibly and another responsibly?

DR. KIRKPATRICK: I think this is just a fact of human nature.

COMMISSIONER FIRESTONE: Well, sir, to come back to the cancellation provisions, you have been saying they have been used rather rarely and in fact they did not lead to a cancellation to but a renegotiation of a contract.

Are these cancellation arrangements standard practice in insurance policies covering not only policies of the voluntary non-profit carriers but also the commercial carriers?

DR. KIRKPATRICK: I cannot speak for commercial carriers, but in the individual contracts of those other plans similar to our own, it is standard, yes.

COMMISSIONER FIRESTONE: When you say other plans similar to your own, you refer to voluntary plans, non-profit plans, or to profit plans?

DR. KIRKPATRICK: Non-profit plans.

COMMISSIONER FIRESTONE: You are not familiar with the terms and type of contracts that your competition in the commercial or profit field offers?

DR. KIRKPATRICK: Not in that detail, sir.

COMMISSIONER FIRESTONE: What portion of your revenue goes into administrative expenses? Just for one year only?

MR. JONES: This past year?

COMMISSIONER FIRESTONE: Yes?

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Your revenue goes into administrative expenses just for one year only?

COMMISSIONER FIRESTONE: Yes.

MR. JONES: The actual overall administration of M.S.I. is 9.48% of premium.

COMMISSIONER FIRESTONE: So, let us say 9½%. Have you put any funds into reserve in that year?

MR. JONES: Yes, sir, we have.

COMMISSIONER FIRESTONE: What proportion, sir?

MR. JONES: In the group plan, 6.09%; in the individual plans, 13.5%.

COMMISSIONER FIRESTONE: Roughly this averages out to, again, about 9.5%. So, in other words, you are paying, speaking of it in approximate terms, you are paying out 81¢ out of the dollar in medical care service?

MR. JONES: In total, sir, yes.

COMMISSIONER FIRESTONE: In total, 81¢ of the dollar. This is approximate, sir. I weighted it on a 50-50% and the 13.5%.

Are you familiar with some of the commercial carriers paying out between 40¢ and 50¢ out of the dollar, as compared with your 81¢?

MR. JONES: I do occasionally see the report from the department of insurance, and I am aware that some carriers do pay a considerably lower amount on claims.

COMMISSIONER FIRESTONE: Would you, then, feel your subscribers are getting a better deal than acquiring or purchasing coverage from these commercial carriers who pay out only 40¢ or 50¢ out of the dollar?

MR. JONES: Is the question, Dr. Firestone, --

M.S.I. is 0.48% of premium.

COMMISSIONER PINSETONE: So, let us say

MR. JONES: Yes, sir, we have.

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MR. JONES: In the group plan, 3.04% in the individual plans, 13.5%.

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MR. JONES: In total, sir, yes.

COMMISSIONER PINSETONE: In total, 81¢ of the dollar. This is approximate, sir. I weighted it on a 70-30% and the 13.5%.

Are you familiar with some of the commercial carriers paying out between 70% and 75% or 76% of the dollar as compared with your 81¢?

MR. JONES: I am generally aware of report from the department of insurance, and I am aware that some carriers do pay a considerably lower amount on claims.

requiring or prohibiting coverage from those commercial carriers who pay out only 40% or 50% out of the dollar?

MR. JONES: In the question, Dr. Pinsetone,

do I feel that they are getting a fair shake from the commercial carriers?

COMMISSIONER FIRESTONE: No, a fair shake from M.S.I.?

MR. JONES: I am quite satisfied they get a very fair shake from M.S.I.

COMMISSIONER FIRESTONE: Thank you very much, sir.

COMMISSIONER McCUTCHEON: You are making no suggestion, then, about commercial carriers at all?

MR. JONES: None at all, sir.

COMMISSIONER BALTZAN: Both M.S.A. and M.S.I. are non-profit organizations, and I am sitting here wondering -- I have not heard of it before -- how do you obtain your subscribers? Do you canvass for subscribers, or is it word of mouth, or shall we use that vulgar word "advertising" for membership?

MR. JONES: Well, Dr. Baltzan, in the early days we pounded on doors and found prospects wherever we could. We had the co-operation of various other bodies, such as the Canadian Manufacturers Association. Very little in the form of advertising through newspaper media or television or other has been used, and largely today our business comes from word of mouth and through the services of persons who have been members and their recommendations to friends and so on.

We do, however, have a field staff who are employed to do both sales and servicing of our accounts, and they, in the end, are the persons in effect who complete the contracts and sign the people up and put the

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business on the books.

COMMISSIONER BALTZAN: Thank you. That answers my questions.

COMMMSSIONER VAN WART: Mr. Chairman, in reading many of the briefs, I notice that chronic alcoholism and drug addiction is very prevalent in Vancouver. Does yourplan cover these groups?

DR. KIRKPATRICK: Dr. Van Wart, they are covered only to the extent of immediate medical attention, but not on a long term basis.

COMMISSIONER VAN WART: That is to say, a person who presents themselves with repeated alcoholic attacks is not covered indefinitely?

DR. KIRKPATRICK: Each illness will be paid for. If it became a continuous thing, he probably would be beyond the need of this. He may be incarcerated in one of the mental institutions.

COMMISSIONER VAN WART: I understand there are not enough of those here.

What is your attitude if he has not been incarcerated?

DR. KIRKPATRICK: Well, the only thing I can say is, from my experience in seeing the accounts, there may be alcoholics who are seen at periods of once a month, for a visit or two for an acute episode, but it does not extend beyond that.

COMMISSIONER VAN WART: How long will you allow that to go on? Two years or ---?

DR. KIRKPATRICK: There is no limitation, sir.

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COMMISSIONER VAN WART: I understand these are not enough to issue [illegible].

What is your estimate if he has not been [illegible]

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COMMISSIONER VAN WART: I understand from reading several briefs that teenagers become drug addicts. Well, naturally, these teenagers, a number of them would be insured through the families. How long do you carry them as drug addicts?

DR. KIRKPATRICK: I have never seen an account rendered for treatment of a drug addict.

COMMISSIONER VAN WART: Is there an exclusion of drug addicts in your contracts?

DR. KIRKPATRICK: It is not an exclusion, sir.

COMMISSIONER VAN WART: Have you any explanation why you have not seen that?

DR. KIRKPATRICK: I cannot hazard a guess.

COMMISSIONER BALTZAN: Maybe they come by another name?

DR. KIRKPATRICK: That is possible.

COMMISSIONER VAN WART: Has that been the experience of the others?

DR. BLACK: I have practised here for 15 years or more in general practice, and I have only seen one drug addict that I know of in my practice.

COMMISSIONER McCUTCHEON: Maybe the other briefs exaggerated a little bit.

COMMISSIONER VAN WART: I was interested to find out your experiences with these people. That is all, Mr. Chairman.

DR. BLACK: I do not believe it has ever been a problem to our plans.

THE CHAIRMAN: Thank you very much, gentlemen.

[illegible]

[illegible] insured through the Jamieson. Did you do you carry

as drug addicts?

[illegible] Department of a drug addic.

[illegible] COURT: Well [illegible] is that a [illegible]

stop of drug addicts in your department?

DR. KIRKPATRICK: It is not an [illegible]

[illegible] COUNSELLOR [illegible] WITT: Have you any

explanation why you have not seen them?

DR. KIRKPATRICK: I cannot [illegible]

COURT [illegible] LAMPLAW: [illegible]

[illegible]

[illegible] WITT: [illegible]

[illegible] of the [illegible]

DR. [illegible]: I [illegible]

[illegible] or more in general [illegible]

[illegible]

[illegible] MCCUNE: [illegible] the [illegible]

[illegible] aggravated [illegible]

[illegible] WITT: I was interested

[illegible], Mr. Chairman.

DR. [illegible]: I do not believe it [illegible]

[illegible]

THE CHAIRMAN: Thank you very much, [illegible]

We will recess for a short time and then continue with the next submission.

---A short recess.

THE CHAIRMAN: We will now come to order and proceed with the submission of the Victorian Order of Nurses for British Columbia.

THE SECRETARY: This will be Exhibit 167.

---EXHIBIT NO. 167: Submission of Victorian Order of Nurses for British Columbia.

SUBMISSION OF

VICTORIAN ORDER OF NURSES FOR BRITISH COLUMBIA

APPEARANCES: Mrs. Roy King
Miss C. Charter

MRS. KING: Mr. Chairman and members of the Commission: I am Mrs. Roy King, President of the provincial organization of the Victorian Order of Nurses for British Columbia and with me is Miss Christine Charter, regional director of the Victorian Order of Nurses for Canada. With your permission I will read the summary of the brief presented on behalf of our provincial group and hope that you might have questions that we will be able to answer.

1. The Victorian Order of Nurses believes that the opportunity for good health is a right possessed by all and should be available in one form or another to every citizen in Canada. It also believes

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MRS. KING: Mr. Chairman and members of the Commission: I am Mrs. Roy King, President of the provincial organization of the Victorian Order of Nurses for British Columbia and with me is Miss Carter, the regional director of the Victorian Order of Nurses for Canada. With your permission I will read the summary of the brief presented on behalf of our provincial group and hope that you might have questions that we will be able to answer.

1. The Victorian Order of Nurses believes that the opportunity for good health is a right possessed by all and should be available in one form or another to every citizen in Canada. It also believes

that a voluntary visiting nursing organization can make an important contribution to the provision of care for patients in their homes, which is an integral part of any community health service.

2. Because of the population density, the nine branches of the Victorian Order in Britisn Columbia are concentrated in the southern section of the province where there is also a relatively high proportion of people in the older groups. Victorian Order services are available to 50% of the total estimated population of the province. The remaining areas are serviced through the public health nursing program of the provincial Department of Health Services and Hospital Insurance.

3. The primary service of the Order, bedside nursing and health supervision, is given in all branches, and includes maternal and newborn supervision. Programs are integrated with those of the local official health agencies. In conjunction with the plan of the provincial Department of Health for the extension of rehabilitation services throughout the province, new programs are being undertaken by the Victorian Order, for example: hospital liaison services, male nursing services, rehabilitation nursing and physical therapy services.

4. It is believed that the establishment of home care programs, hospital or community centered, would provide a range of services for patient care at home, planned on an individual basis. It would also provide for the releasing of hospital beds

that a voluntary visiting nursing organization can make an important contribution to the provision of care for patients in their homes, which is an integral part of any community health service.

2. Because of the population density, the cities are concentrated in the southern section of the province where there is also a relatively high proportion of people in the older groups. Victorian Order services are available to 90% of the total estimated population of the province. The remaining areas are served through the public health nursing program of the provincial Department of Health.

3. The primary service of the order, home nursing and health supervision, is given in patients' homes, and includes maternal and newborn supervision. Programs are integrated with those of the local official health agencies. In accordance with the plan of the provincial department of Health for the extension of rehabilitation services throughout the province, new programs are being undertaken by the Victorian Order, for example, occupational therapy services, safe nursing services, rehabilitation nursing and physical therapy services.

4. It is believed that the establishment of home care programs, hospital or community sponsored, would provide a range of services for patients sick at home, planned on an individual basis. It would also provide for the releasing of hospital beds

for patients requiring the facilities of acute hospitals or rehabilitation centres. The Victorian Order of Nurses could be used to provide the necessary visiting nursing services inherent in such a plan where its branches are located.

5. Extension of rehabilitation services of all types is desirable for patients in boarding homes as well as in the home. The Victorian Order could be a co-ordinating agent in addition to providing some of the visiting services required.

6. In view of the relatively high proportion of people in the older age groups in British Columbia it is desirable that facilities designed for their assistance and benefit, e.g. housekeeping services, should be set up and/or expanded. Limited assistance of this sort is being provided to selected patients of all types, who are under Victorian Order care in the branches in British Columbia, through the Lord Strathcona Fund.

7. In view of service needs experiences, efforts have been made to use a variety of personnel. It has been the experience of the Vancouver branch that service needs can be more adequately met by employing nursing practitioners differentiated on the basis of function and preparation, for example, male registered nurses and nursing assistants. The use of nursing assistants is limited at present to the Vancouver branch so that standards of service may be safeguarded through the maintenance of a suitable ratio of professional staff. It is

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5. In view of the relatively high proportion of people in the older age groups in British Columbia it is desirable that facilities be made for their assistance and benefit, e.g. housekeeping service, should be set up and/or expanded. Further assistance in this case is being given by the personal, private, and all types who are under Victorian Order care in the branches in Prince Rupert, through the Grand Forks Hospital.

In view of service made experience, it has not been made to see a variety of personnel. It has been the experience of the Vancouver Branch that service people can be more adequately met by employing nursing personnel differentiated on the basis of location and preparation, for example, male registered nurses and nursing assistants. The use of nursing assistants is limited at present in the Vancouver branch so that standards of service may be safeguarded through the maintenance of a suitable ratio of professional staff. It is

believed that the services of male registered nurses would meet specific service needs in other branches.

8. The Victorian Order is anxious to co-operate to the fullest extent with official health agencies in our communities, and in addition to the planning of programs it has been possible to integrate office accommodation with that of the local official health groups in most branches. This proximity has promoted co-ordination of services and contributes to the prevention of duplication of effort.

9. The branches in British Columbia are financed by means of municipal and provincial grants, fees from patients, and contractual arrangements. The provincial Department of Welfare grant is distributed through the provincial Victorian Order Association to the branches on a pro rata basis for services to wards of government. This amounts to approximately one-third of the cost of service to this group of patients. The Department of Health is assisting financially with the provision of some additional personnel for the extension of rehabilitation services. There has been a reduction in revenue from patients' fees and member branches of certain community chests and councils are also experiencing reduction in budget allocations which may affect their functioning unless other sources of income can be found. In areas where the Victorian Order becomes restricted in its

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9. The branches in British Columbia are financed by means of municipal and provincial grants, fees from patients, and contractual arrangements. The provincial Department of Welfare grant is distributed through the Provincial Victorian Order Association to the branches on a per capita basis for service to wards of government. This amounts to approximately one-third of the cost of service to this group of patients. The Department of Health is assisting financially with the provision of some additional personnel for the activities of rehabilitation services. There has been a reduction in revenue from patients, and some branches of certain community charts are also experiencing reduction in budgets as corporations which pay a fee have difficulty; and other sources of income can be found. In areas where the Victorian Order become restricted in its

function of providing essential visiting nursing services because of financial agreements entered into with community chests and councils, it may be necessary to explore the possibility of seeking additional sources of revenue. As long as there is a need for Victorian Order services, efforts will be made to find ways and means of financing it.

10. A foregone conclusion of all the material herewith submitted is that the Victorian Order of Nurses for British Columbia is willing to co-operate with any health and welfare plans set up for the benefit of the people of this province.

THE CHAIRMAN: Thank you very much, Mrs. King.

COMMISSIONER GIRARD: Mrs. King and Miss Charter, I would like to start out by congratulating the Victorian Order of Nurses of British Columbia for being first in a number of endeavours. I believe you were first in employing male nurses; I also believe that you were first in employing physiotherapists. You were not first in employing nursing assistants but at least you were a good second best and took up the example of Toronto very shortly after they had tried it. This is undoubtedly a progressive organization.

If you do not mind, I would like to start out with a question that I asked in Victoria of the V.O.N. branch and since you are talking for all the branches of the province I think I can bring it up again. It was suggested that the liaison service that you have in the

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If you do not mind, I would like to start out with a question that I asked in Victoria of the V.O.N. branch and since you are testifying for all the branches of the province I think I can bring it up again. It was suggested that the Nursing service that you have in the

hospital did not produce the results that we were accustomed to expect from these services by the brief that we have received from the V.O.N. in other provinces. Do you have any explanation for this?

MISS CHARTER: The liaison services have been quite recently set up in this province and they are generally rather slow in developing. I think the impression that was given in Victoria was partly resulting from the fact that the District of Saanich and Victoria City are separate and the number of referrals to the Victorian Order of Nurses in the city of Victoria are considerably higher than those being made to the area of Saanick which is serviced by the Provincial Department of Public Health Nursing. The total referrals for 1961 through the liaison services in the three hospitals including Gorge Road Chronic Treatment Centre in Victoria were 2,361. A fair number of these certainly were in the obstetrical area but 271 were medical and surgical patients referred through this service. The percentage increase over 1960 was 66%, that is in the second year of operation. In Vancouver City, the larger liaison services, the increase of 1960 over 1960 is exactly 100%. We feel as these services become better known and interpreted to both medical and nursing staff as well as the general public they will be used more extensively.

COMMISSIONER GIRARD: That is a lot more encouraging than what we have heard. I think we had not been shown the whole picture. I have the figures here for only one year and that accounts for it and I was really surprised that it was such a low figure. Now, this question

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COMMISSIONER STEARS: That is a lot more encouraging than what we have heard. I think it had not been shown the whole picture. I have the figures here for only one year and that accounts for it and I see really

of employing male nurses, you have two on the Vancouver branch; how easy or how difficult is it to recruit male nurses?

MISS CHARTER: There is a scarcity of prepared male registered nurses. We had, after advertising, approximately a half a dozen applications which we could consider. This service has to become better known. Since we have employed male R.N's. we have received other applications but there is definitely a shortage in this area.

COMMISSIONER GIRARD: Are they registered nurses or registered nurses plus public health qualifications?

MISS CHARTER: No, they had not the public health qualifications.

COMMISSIONER GIRARD: I think there are very few R.N's. in Canada that have public health.

MISS CHARTER: I believe so.

COMMISSIONER GIRARD: Do you think these male registered nurses will be encouraged to get public health thus leading the way for others? Do you think they seem to be interested in public health nursing?

MISS CHARTER: Yes, I can only speak for two of them but one of them is certainly interested in pursuing public health.

COMMISSIONER GIRARD: Because this is looked on by other branches as something they have to get. One V.O.N. brief in another province mentioned this and I believe they were eager to do the same. In paragraph 20 on page 6 you speak of the employment of a full-time physio-

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MISS CHAPTER: No, they do not have public health qualifications.

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therapist being employed by the Vancouver branch since October 1961. This physiotherapist I see is mostly consultant to the nursing staff and provides limited service on a visit basis to patients at home. What would be your fee for a visit in the home of the physiotherapist? Will it be the same as an R.N. or do you have a different fee for those who can pay the fee?

MISS CHARTER: The maximum fee per visit, exactly the same as any service provided by the organization.

COMMISSIONER GIRARD: So whether the therapist goes to the home or whether the nurse goes it is the same fee?

MISS CHARTER: The maximum fee, yes.

COMMISSIONER GIRARD: And if the patient cannot pay it is the same philosophy of the Order, it is on a sliding scale for those who cannot pay, it still remains the same?

MISS CHARTER: Yes.

COMMISSIONER GIRARD: Now, on page 7 in paragraph 24 you speak of housekeeping services and we have been hearing a lot of these services because this seems to be one facility that a lot of organizations are lacking. I realize that the housekeeping services that you offer are offered only to patients while they are getting V.O.N. service.

MISS CHARTER: That is right.

COMMISSIONER GIRARD: This means this housekeeping service is in the V.O.N., it is part of the V.O.N. and this is only for V.O.N. patients?

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COMMISSIONER GIRARD: Do you have more than one or are they employed on a salary or part-time basis?

MRS. KING: They are employed by the hour or by the day depending on the need for the case to which they are sent. Consideration is being given to employing on a monthly basis because of the fact that it is difficult sometimes to get a person when they need one and if they are employed on a full-time basis we would have them. This has just been private and has been considered in the Vancouver branch. We need more people.

COMMISSIONER GIRARD: If you have a housekeeper in the home where you are going for nursing purposes and these people cannot pay the fee of this housekeeper it comes out of your general funds?

MRS. KING: Out of the Lord Strathcona Funds.

COMMISSIONER GIRARD: What would happen if you are visiting a patient for nursing services, you have a housekeeper visiting the patient also and the services of the nurse are not needed any more but the services of the housekeeper are still need, what would you do with the housekeeper services? Would you have to terminate the housekeeper services at the same time that you terminate the nursing services under the understanding you have here?

MRS. KING: I think that would depend on the cases. Perhaps Miss Charter has had some experience with that.

MISS CHARTER: Our general rule is that when V.O.N. services terminate if possible we terminate the

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services of the housekeeper. However, we have made exception to this where it would have been detrimental to the patient.

COMMISSIONER GIRARD: You can foresee occasions where this could happen?

MISS CHARTER: Yes, this is the reason why in the new private project which is being planned in one of the branches, this particular problem is being considered and other arrangements may be set up to care for it.

COMMISSIONER GIRARD: Miss Charter, I also made a note here when this pilot project is finished would you like to send the Commission a copy of the report? I think we would be very interested in getting a copy of the report. When do you think the pilot project will be finished?

MISS CHARTER: It is rather difficult to say just at the present, but we would anticipate it might be by Fall of this year that it would be completely set up, but not sooner than that.

COMMISSIONER GIRARD: We would be happy to get a copy of this pilot project report. Page 8, paragraph 29 you say that the Vancouver branch during the past five years have awarded three bursaries of $1,000.00 to nurses who returned to that branch. For how long must the nurses return to be eligible for the $1,000.00 bursaries?

MISS CHARTER: The return has been a one-year period.

COMMISSIONER GIRARD: One year, that is the same length of time as for the nurses resident and registered in British Columbia but born in Britain who get bursaries

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COMMISSIONER GIRARD: One year, that is the same length of time as for the nurses resident and registered in British Columbia but born in Britain who get bursaries

from the Lord Strathcona Fund. Does the same thing apply, they have to work a year for the $1,000.00 bursary?

MISS CHARTER: Yes.

COMMISSIONER GIRARD: This Lord Strathcona Fund, is this only for nurses born in Britain resident and registered in British Columbia?

MRS. KING: Yes, I am sorry to say, Miss Girard, that is so. The Fund originally was set up to assist indigent English gentlewomen and the fund wasn't used, and after many years they were able to have it changed over so the fund might be used for the purposes of education and the Victorian Order receives bursaries, five $1,000.00 bursaries under that fund, and the surpluses of that fund if not used for education may be used for our housekeeping fund. It took many years to set up this arrangement for the Victorian Order. We are not too happy about that because it is so limiting. We have had it two years with the bursaries available and we have had only one application for each year.

COMMISSIONER GIRARD: How many available each year?

MRS. KING: Five.

COMMISSIONER GIRARD: You have only one application?

MRS. KING: Only one, but we hope time may change this again, that it may be enlarged, because there is a definite need for bursaries.

COMMISSIONER GIRARD: I am happy to see nurses are gentlewomen. It was set up for gentlewomen and they gave it over to the nurses. It seems that we are

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in the same category. Under the employment of nursing assistants, I am happy to see here you are making some provision for a good working ratio of nursing asistants to R.N's. You specify that the ratio should be one to twelve. I am sure that you came to this conclusion after some experimentation. Would you care to tell us about that, how you came to this ratio of one to twelve?

MISS CHARTER: It was felt in order to safe-guard the standard of nursing services that has always been the policy of the Victorian Order, that we must provide adequate supervision for this type of nursing personnel, and therefore a certain number of visits per patient must be made by the prepared nurses in public health and in order to work out that with the number of patients in Vancouver this was the ratio that we were able to establish.

COMMISSIONER GIRARD: There are only certain specific functions that the nursing assistant can perform, I assume?

MISS CHARTER: Yes.

COMMISSIONER GIRARD: And the amount of these functions wouldn't be, the nurses wouldn't be able to use the nursing assistants for all work, the case-load of twelve nurses goes to make up the case-load of one nursing assistant?

MISS CHARTER: That is what our experience was.

COMMISSIONER GIRARD: Then I see it is the policy that the nursing assistant is not allowed to admit or discharge a case. I can see the reasons for that.

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Would you like to tell us why?

MISS CHARTER: It is felt a nurse with experience in dealing with all types of cases and conditions should be present to assess the situation when a patient is admitted and again when the time comes for discharge to make the decision or be responsible for the decision when this particular patient under his doctor's supervision is able to manage without further nursing care, that this responsibility should not belong to the practical nurse or nursing assistant who has limited experience in all types of nursing situations.

COMMISSIONER GIRARD: I think that is a good safeguard. Now, on page 12 you say that fees received directly from patients amount to almost $13,000.00 less than in 1959. You said that at the beginning too in the summary. Do you have any reason to give why the fees were less? Did you have less paying patients? What would the reasons be?

MISS CHARTER: We feel, Mr. Chairman, Miss Girard, that this refelcted possibly, partially at least, the economic situation in the area during that period of time, the cost per visit -- in each branch, as you know, are computed annually. These costs have been rising. The fee charged therefore, the maximum fee charged is also raising in proportion and this is reflected in far fewer paying visits over a period of time with an increase on part paid and free visits. We also feel with pre-payment insurance schemes, they have affected fee collection somewhat because naturally people who can obtain services, the services required at their doctor's office, if they are able

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to go will not be so likely to wish to be referred to a visiting nursing organization where generally payment has to be made for this service.

COMMISSIONER GIRARD: Do any of the prepaid medical plans provide for nursing services?

MISS CHARTER: We have had contracts with one or two groups, but these are extremely minor situations and affect only a very small number of our patients.

COMMISSIONER GIRARD: This has been explored with these groups? Has it been discussed and looked into?

MISS CHARTER: Not officially.

MRS. KING: There have been certain incidents, requests have come from individuals that this become part of the pre-paid medical plan so enquiries have been made as to including this and it was said that requests would have to come from a group to the company, to the body for such a plan.

COMMISSIONER GIRARD: There was no further follow-up?

MRS. KING: Nothing further.

COMMISSIONER GIRARD: Mrs. King or Miss Charter, would you like to make any comment on what was said yesterday in the Public Health Officers' brief regarding bedside nursing care being given by public health nurses instead of voluntary agencies?

MRS. KING: With your permission I would ask Miss Charter to speak to that.

MISS CHARTER: I would, if I may, at this time like to correct an impression which may have been left as the result of that hearing, that the voluntary

to go will not be so likely to wish to be referred to a visiting nursing organization where generally payment has to be made for this service.

COMMISSIONER GIRARD: Do any of the prepaid medical plans provide for nursing services?

MISS CHARTER: We have had contracts with one or two groups, but these are extremely minor situations and affect only a very small number of our patients.

COMMISSIONER GIRARD: This has been explored with these groups? Has it been discussed and looked into?

MISS CHARTER: Not officially.

[illegible] requests have come from individuals that this become part [illegible] as to including this and it was said that requests would have to come from a group to the company, to the body or such a plan.

COMMISSIONER GIRARD: There was no further follow-up?

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COMMISSIONER GIRARD: Mrs. King or Miss Charter, would you like to make any comment on what was said yesterday in the Public Health Officers' brief regarding bedside nursing care being given by public health nurses instead of voluntary agencies?

MRS. KING: With your permission I would ask [illegible] to comment on that.

MISS CHARTER: I would, if I may, at this time like to correct an impression which may have been left as the result of that hearing, that the voluntary

agencies had been, more or less, unwilling to expand services in British Columbia. This is, as you know, undertaken, this expansion is undertaken when a request comes from a community to our National Organization and investigation proves that there is an interested group in the community which is willing and able to finance the undertaking. The other requirement is that the official approval of the medical officer of health of that district must also be secured. To the best of my knowledge these requests have come from numerous communities in British Columbia during the last ten or fifteen years, but the Victorian Order has not been encouraged to organize branches in these particular areas. I believe it is the general policy of the provincial organization to implement a bedside nursing programme completely throughout the province in areas where the Victorian Order is not already organized and this, as you know, is being done. I am not prepared at this time to offer any comment as to the extent of services provided in other areas.

COMMISSIONER GIRARD: Thank you very much, Mrs. King and Miss Charter.

THE CHAIRMAN: Dr. Baltzan?

COMMISSIONER BALTZAN: No questions, sir.

COMMISSIONER VAN WART: Mr. Chairman, just for my own information, on page 2 you mention the Lord Strathcona Fund. Would you please inform me concerning that fund?

MRS. KING: Mr. Chairman, Doctor, this is the fund I was speaking of to Miss Girard that has been given to the Victorian Order of Nurses for British Columbia,

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COMMISSIONER GIRARD: Thank you very much.

THE CHAIRMAN: Dr. Seitzer?

COMMISSIONER SEITZMAN: No questions, sir.

COMMISSIONER VAN WART: Mr. Chairman, just for my own information, on page 2 you mention the Lord Strathcona Fund. Would you please inform me concerning that fund?

MRS. KING: Mr. Chairman, Doctor, this is the fund I was speaking of to Miss Girard that has been given to the Victorian Order of Nurses for British Columbia,

for use purely in this province. It is used purely for education and we have available to us five $1,000.00 bursaries for nurses who are resident and registered in the Province of British Columbia who must take their public health training in British Columbia and be prepared to serve for one year following completion of the training in a branch in British Columbia. The amount of the fund which is not used for educational purposes is provided to us for the use of housekeeping services to patients of the Victorian Order who are not eligible under any other plans for such services and are not able to provide such services for themselves.

COMMISSIONER VAN WART: How was this fund created?

MRS. KING: Do you mean where it originally came from?

COMMISSIONER VAN WART: Yes.

MRS. KING: It was set up, I cannot give you the exact date, many years ago it was set up to provide for indigent English gentlewomen who might have come to Canada and found themselves financially unable to provide for themselves.

COMMISSIONER VAN WART: Who created it?

MRS. KING: The name of the fund, the Lord Strathcona Fund I believe would give us an indication.

COMMISSIONER VAN WART: Did the come from Lord Strathcona?

MRS. KING: From the Lord Strathcona Fund, and it lay idle for many, many years, and then eventually went through the Courts and this change was made so we were

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able to get it. I hope I have been able to make that clear.

COMMISSIONER VAN WART: Thank you. On page 16 is the first of your tables. You have a series of tables and many interesting observations can be made from these tables. There are many things which could be considered. I don't want to go into that other than to make some observation. In table 2 on page 16 out of 5,150 cases there were 330 cases one year and over and the number of visits made in the overall picture is 57.3% made to these 330 patients out of a total of 5,000-and some odd patients. That is a very large number of visits to one group of patients. It stems over a year and more. Coming to table number 3 on page 17 your observation is the same number of cases, 83% of your visits were to people of 65 years and over and following through into your table number 4, diseases of the heart took 20,000 visits out of 75,000 visits in total, which is a very, very high percentage. That would be about 27% of the visits were given to diseases of the heart. I just make those observations because we can come to conclusions and see the problems these raise as to the volume of your work.

THE CHAIRMAN: Thank you very much Mrs. King and Miss Charter. This brief added to the others we have had from the Victorian Order of Nurses will be of much assistance.

We will now hear from Mr. Kelly who will be reading the brief on behalf of the Elder Citizens Association. It will be 168.

MR. KELLY: Mr. Chairman, members of the

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We will now hear from Mr. Kelly who will be reading the brief on behalf of the Elder Citizens Association. It will be 168.

MR. KELLY: Mr. Chairman, members of the

Commission, the brief which I have was prepared for presentation on Saturday originally, as you know, and on a call from one of your staff it was changed to Friday.

THE CHAIRMAN: If you are prepared to give it now we will be glad to hear it. If you prefer to wait until the original time it is entirely up to you, Mr. Kelly.

MR. KELLY: My preference would be to wait till Friday.

THE CHAIRMAN: That is very good. If you prefer to wait we will wait.

MR. KELLY: I would prefer to. Thank you.

THE CHAIRMAN: We will have the brief of the C. U. & C. Health Services Society. We will strike the other brief and make this one number 168.

THE CHAIRMAN: We will now proceed with the C. U. & C. Health Services Society, if they are ready.

---EXHIBIT NO. 168: Submission of C. U. & C. Health Services Society, Vancouver.

---EXHIBIT NO. 168A: C.U.&C. Financial Statement, January 1962.

---EXHIBIT NO. 168B: Supplement to schedule 6A in the brief and extracts from Canadian Sickness Survey 1950-1951 Bulletin 9, Published in 1956 by Queen's Printer and issued by Dominion Bureau of Statistics.

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SUBMISSION OF

C. U. & C. HEALTH SERVICES SOCIETY

APPEARANCES: H. C. Hunter
Mrs. Higginbotham
J. H. Corsbie
R. J. McMaster
Wm. Black
Gary Coulter

THE CHAIRMAN: Mr. McMaster?

MR. McMASTER: Yes, Mr. Chairman, and members of the Commission, our Society considers it a privilege to be able to appear before this Commission and express its views with regard to this very important matter and be of what assistance we can to the Commission.

I am the legal counsel for the Society. We thought it might be desirable if the general questions might be directed to me to speed up the proceedings after I have read the summary.

I have associated with me persons knowledgeable with regard to particular aspects of the Society's affairs. I would like to introduce them to the Commission. On my right, Mr. Hunter, the President of the Society; Mrs. Higginbotham, Claims Officer of the Society, Mr. Corsbie, the General Manager. On my immediate left, Mr. William Wright, my associate in the practice of law who was responsible for the preparation of the schedules in the brief. And on his left, Mr. William Black, a director of the Society, and on his left, Mr. Coulter, the field representative with the Society.

Before I proceed with the summary, Mr. Chairman, I would like to file some additional material by way of schedules which might be helpful. Schedule 2 of

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Before I proceed with the summary, Mr. Chairman, I would like to file some additional material by way of schedules which might be helpful. Schedule 2 of

the brief as filed is the last year's financial statement. I have a more recent statement that is not audited which has been taken off, and which may possible verify some of the material in the brief.

THE CHAIRMAN: That will just be incorporated in the folder in the back of the submission?

MR. McMASTER: Yes, it could be as an addition to schedule 2. I will hand this to the secretary in a moment.

The second addition I would like to make is an addition to schedule 3. Schedule 3 is a pamphlet which gives a summary of the benefits which are offered by this Society. I thought it might be helpful to the Commission to have the actual regulations which apply.

THE CHAIRMAN: Thank you. Yes, it would be.

MR. McMASTER: You will find when I refer to the by-laws that with regard to group coverage, particularly, the directors have certain discretions in setting regulations dealing with the coverage, and I realized afterwards that probably fuller information might be useful to the Commission.

In regard to schedule 6, which you will see by the table of contents refers to health care obtained by income groups, schedule 6 was prepared, I think, a little bit more summarily than perhaps ought to be in terms of it being a document which is a useful reference to the Commission. I think the material in it is correct, but the material in that schedule was taken from a publication of the Dominion Bureau of Statistics of the Dominion

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Government dealing with the Canadian sickness survey of 1950-1951.

The Commission, no doubt, would be aware that such a survey was taken by the government in that year. The figures in the survey, of course, relate to the survey year which, I think, immediately preceded the publication and D.B.S. has since that time published nine bulletins dealing with the material in that survey. Bulletin No. 9 in particular deals with the volume of health care for selected income groups.

I might just read one very short statement from the introductory part of it, which says that the present bulletin covers substantially the same categories and measures of health care, but the breakdown of the national estimates in this case is by income group, for some of the more common categories of health care, physician care, or in-patient hospital care, and I think further breakdown is divided by income figures by age groups and sex.

I will file this after lunch, if I might. I can file bulletin No. 9 now, the only copy I have, with the Commission, if that would be helpful.

THE CHAIRMAN: We will be able to get the bulletin from the Department?

MR. McMASTER: Yes, I appreciate that very much, but the one further comment I would like to make is that dealing with incomes at the 1950 level.

THE CHAIRMAN: Right.

MR. McMASTER: In order to relate that to present different conditions, it seems to me that reference

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could be made to schedule 4 in our brief which deals with cost of living index and cost of medical costs, and I think when you do relate the figures with those indexes in mind that the material becomes more relevant.

And then I would add a further schedule, which would be schedule 12, sufficient copies of which I have with me now for the Commission, and I would like to place in their hands now, and I will give these to the secretary. This may be a little presumptuous on my part, sir, but we felt in preparing for this hearing that we ought to try to anticipate the kind of questions arising out of the brief the Commission would be interested in having specific answers to. It was my privilege to hear the Commission hearings in Victoria the other day and to get some indication of some of the problems which they were pursuing, and we have endeavoured in a short form of summary here to deal with a variety of questions which there may not be time enough to deal with today, but which may ultimately be helpful to the Commission. I would ask to file those, if I might.

Turning to page 1 of the brief, immediately following the index is the summary. I have already introduced my associates.

Costs of health care spiralling Pages 3 - 10

Schedules 1, 2 and 4.

It is the submission of the Society that the individual alone, is unable in the face of rising costs of health care, to make adequate provision for the maintenance of his health. In recent years, costs of medical,

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It is the submission of the Society that the individual alone, is unable in the face of rising costs of health care, to make adequate provision for the maintenance of his health. In recent years, costs of medical,

dental, optical and related health services have spiraled at a far faster rate than the overall cost of living and disproportionately to the rise in income.

Prepaid plans have assisted within limits

Prepaid insurance plans such as the one provided by this Society have assisted the individual, who can afford them, to meet this problem. Unfortunately, such plans are not available to many classes of society. For economic reasons these plans must generally exclude the aged, the chronically ill and permanently disabled and the indigent as well as many persons when unemployed. Prudent planning and co-operation has helped but it is not a sufficient answer to the problem.

Our Society and organizations providing similar services have also found increasing difficulties in maintaining an adequate service and full benefits and at the same time keeping their operations within the budgeting power of those whom they serve. Although administrative costs have been kept to a minimum, it has been increasingly difficult to maintain adequate services.

Co-operative plan the solution

A national health program operated on the same co-operative principles as our Society now operates it is submitted is the only solution to the problem of adequate health care.

Present health and welfare activities inadequate
Pages 10 - 13 Schedule 5

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extensive but they are not co-ordinated. While they are not fully utilized they are in fact, frequently over-burdened. We have in a schedule annexed to the brief endeavoured to give a comprehensive, though not exhaustive outline of some of the services available in this province through government, private and voluntary agencies.

A general, overall co-operative effort, co-ordinating these many services and providing for their expansion will bring unity and make greater utilization of the services available. In many areas services are insufficient or inadequate and must be expanded. We submit that co-operative planning is the answer to this problem. It is not in our submission adequate to provide health care piecemeal.

Good health is the right and responsibility of every citizen. Pages 13 - 20 Schedules 6 and 9.

Good health care is the right and the responsibility of every citizen. If the individual is willing to accept the responsibility for maintaining his health so far as his ability permits, there should be available to him the facilities and services to do so. It is our belief that a definition of good health means not only alleviation and freedom from pain but a complete state of mental, physical and social well being. No citizen should be denied the exercise of this right for lack of financial abilaity.

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Our Society appreciates that the cost of

providing such service is high. However, voluntary plans have demonstrated, on a lesser scale, that by budgeting and pooling costs and co-operative efforts a solution can be found. They are, however, limited in scope. Only through co-operative planning at a national level with leadership from the senior government can the problem in our view be adequately met.

A national health scheme must be all inclusive:

It is our submission that a national health program must be inclusive of all the healing arts and sciences. It must embrace prevention, diagnosis, treatment, rehabilitation, research and education. Other nations are seeking to meet this problem on a co-operative basis. We are persuaded that Canada must do likewise.

Long term savings will offset initial costs - illustrations.

Pages 23 - 29 Schedules 9 and 10

The solution may be costly but evidence indicates that long term savings will result. Health programs undertaken in the past illustrate that although initial costs may be heavy, in the long run they result in savings and benefit to the economy. Institutional treatment and rehabilitation costs are reduced. Examples of such long term planning may be taken from programs undertaken in the communicable diseases, tuberculosis and other fields. Many diseases have thus been stamped out or controlled. Freedom from disease means the individual can assert a more productive role in the community. We submit that a national health program, although initially requiring

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high expenditures, will result in long term savings thus offsetting initial costs.

Recommendations Pages 29-11 Schedule 11:

Accordingly we make the following recommendations:

Comprehensive and universal:

(1) A national health program must provide comprehensive health care for all citizens without regard to means. The scheme should be contributed to by all citizens and its benefits should be available to all who wish to avail themselves of it.

Adequate remuneration by salary method:

(2) An adequate remuneration should be provided for all persons in the healing arts and sciences based upon the salary method which we consider to be the method providing the greatest control of quality commensurate with the skills exercised, and resulting in the least administrative and bureaucratic difficulties.

Group practice:

(3) Encouragement should be given to group practice among those engaged in the healing arts and sciences. The co-operation of professional organizations should be enlisted to this end. We believe that this will provide benefits to both patient and practitioner, and will at the same time assist in the control of rising costs occasioned by new advances and techniques.

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Freedom of choice:

(4) Practitioner-patient relationship should be a matter of free choice regulated only by availability and geography and questions of professional ethics.

Training programs:

(5) Scholarships and training centres should be made available to all qualified persons irrespective of means. This will provide the necessary trained personnel to implement and operate a national health program and will help to alleviate the deficiency of trained personnel presently found in many areas of the healing arts and sciences.

Research:

(6) The provision of further funds and facilities to continue and expand research and to educate the public as to the importance of good health care. This must be an integral part of a national health program.

Co-operation and leadership:

(7) The co-operation of all levels of government, and all lay, professional and service organizations should be encouraged. Leadership should be provided by the federal government but programs for constitutional and geographic reasons should be conducted through a decentralized administration.

Further study of costs and financing:

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facilities available to it should undertake a thorough study of all aspects and methods of financing a national health program. Certain initial expenditures and a portion of continuing costs of administration must come from general revenue and taxes. We propose that Government Health Bonds underwritten by the government be issued with a view to amortizing them over long periods through savings and increased revenue resulting from higher productivity of a healthier population. Some financing may also be done through co-insurance methods which we believe will have the added purpose of preventing abuses.

Interim planning:

(9) In the interim period necessary for implementation of a national health program the government should take immediate steps to indicate its interest in health care. Voluntary plans should be subsidized to encourage the extension of their services and benefits to persons not presently covered. They should be underwritten by the government to assure their liquidity and facilitate the change over when a full national plan is implemented. Additional funds should be made available for training qualified personnel. Funds should also be made available to expand research work. Certain areas require immediate attention - mental health, the degenerative diseases, the crippling and disabling diseases and dental health. With a view to the eventual implementation of a comprehensive national health program the co-operative of all interested organizations should be enlisted.

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Democratic Participation:

(10) In implementing a national health program the maximum opportunity for individuals and groups to participate in its planning and administration should be provided on the broadest principles of democracy commensurate with efficiency.

That is the summary of our submission.

THE CHAIRMAN: Thank you, Mr. McMaster. I might say that your idea of trying to anticipate what questions might be asked and you have given us answers to those questions can possibly be very helpful. However, so as to be helpful, we must have a chance to look at them.

Perhaps we shall recess now until two o'clock when we will proceed and it is quite likely when we have a chance to look at the questions and the answers, you may have well covered all the aspects on which you have been questioned.

---Luncheon adjournment.

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---Upon resuming.

MR. McMASTER: I have just stated for the purposes of the record, Mr. Chairman, that we filed as Exhibit 168A the last financial statement of the Society together with three sets of regulations governing the views and benefits of varying types of members of the Society and as Exhibit 168B a supplement to Schedule 6A of the brief and two extracts from the Canadian Sickness Survey 1950-1951 Bulletin 9, published in 1956 by Queen's Printer and issued by the Dominion Brueau of Statistics and as Exhibit 168C a series of questions which we anticipated might arise out of the brief which has been submitted and an attempt to answer those questions. Thank you.

THE CHAIRMAN: Thank you, Mr. McMaster. I note the documents which you have provided us with, Mr. McMaster contain the number of members. Is that figure of 35,900?

MR. McMASTER: I think you will find, sir, that refers to group members and the beneficiaries of group plans and individual plans.

THE CHAIRMAN: How many members have you?

MR. McMASTER: Well, actually, sir, of which there would appear to be .....

THE CHAIRMAN: The report for 1960 shows 32,136. That was at the end of 1960. At the end of 1961, would you have that figure?

MR. CORSBIE: The report lists heads of families.

THE CHAIRMAN: Number of members on year end.

---Upon resuming.

MR. McMASTER: I have just stated for the purposes of the record, Mr. Chairman, that we filed as Exhibit 1686A the last financial statement of the Society together with these sets of regulations governing the views and benefits of varying types of members of the Society and as Exhibit 1688B a supplement to Schedule 6A of the brief and two extracts from the Canadian Sickness Survey 1950-1951 Bulletin 9, published in 1956 by Queen's Printer and issued by the Dominion Bureau of Statistics and as Exhibit 1688C a series of questions which we anticipated might arise out of the brief which has been submitted and an attempt to answer those questions. Thank you.

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THE CHAIRMAN: The report for 1960 shows 32,130. That was at the end of 1960. At the end of 1961, would you have that figure?

MR. CONSMIR: The report lists heads of families.

THE CHAIRMAN: Number of members on year

MR. CORSBIE: Heads of families.

THE CHAIRMAN: How many individuals does that cover?

MR. McMASTER: That covers 77,091 beneficiaries in the group plan and 35,900 persons covered under individual coverage which might be a man and his dependants.

THE CHAIRMAN: You haven't reached me yet. You start with 32,000 members, those are heads of families. Back to the 112,000 people.

MR. McMASTER: This is areas. Perhaps the simplest ...

THE CHAIRMAN: Is that what you mean?

MR. McMASTER: No, what I mean, the situation is this, we have a number of individual members in the Society, we have a number of persons who are what we call representative members of the Society, the dependants of the individual members are covered by the benefits of the individual coverage. As to the group representatives they may be, for instance, the officers of an association or of a group. They would appear as members, but we cover not only them, but the whole group they represent as beneficiaries and their dependants, so that the total coverage of persons is much greater than what actually appears as membership of the Society.

THE CHAIRMAN: It would be 77,091 plus 99,100?

MR. McMASTER: That is correct, that is the number of persons covered, the actual membership is approximately in the neighbourhood of 35,000.

THE CHAIRMAN: What is the geographic

MR. COMPTON: Heads of families.

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THE CHAIRMAN: What is the geographic

distribution in the Province?

MR. McMASTER: The main geographic distribution would be in what we call the lower Fraser Valley and on Vancouver Island. However, the Society has groups now pretty well extended throughout the Province of British Columbia, in every part.

THE CHAIRMAN: You may sit down, Mr. McMaster. Now, is this stating your proposal correctly: That you advocate an overall health service program including physician services, dentists and the other healing arts?

MR. McMASTER: Yes, that is correct.

COMMISSIONER STRACHAN: Drugs?

MR. McMASTER: We haven't specifically dealt with drugs. I think that we would, if they were included as an ancillary to an overall health service program.

THE CHAIRMAN: You are suggesting that the doctor should be on salary?

MR. McMASTER: That is right.

THE CHAIRMAN: The same with dentists?

MR. McMASTER: Yes.

THE CHAIRMAN: What about the others, everybody else?

MR. McMASTER: Nurses?

THE CHAIRMAN: Nurses.

MR. McMASTER: The nurses and other people associated together in the healing arts.

COMMISSIONER McCUTCHEON: Who provides the doctors' offices? Under your scheme, who would provide the

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COMMISSIONER MACDONALD: Who provides the doctors' offices? Under your scheme, who would provide the

doctors' offices?

MR. McMASTER: Presumably these would have to be provided by the scheme, the place of operation, the clinics would be provided by the scheme.

COMMISSIONER McCUTCHEON: Provide them with motor cars?

MR. McMASTER: I don't know if we would go quite that far. It is all in how necessary it is in the use of the practice. It is hard to say at what line it is necessary in a practice.

COMMISSIONER McCUTCHEON: Equipment?

MR. McMASTER: And their equipment, yes. In other words, we are talking about clear salary and not about gross sala out of which they are obliged to meet the operating expenses of group practise or however it was set up.

COMMISSIONER McCUTCHEON: That would mean, of course, somebody would have to make the determination of what equipment the doctor is allowed to have, what instruments in his bag, in the laboratory, what laboratory equipment he would have in his office.

MR. McMASTER: In administration, I think when it comes to medical men, that the Commission should accept that the experts in the field would be the people who could advise as to what was required.

COMMISSIONER McCUTCHEON: I suggest there have been occasions when administrative authorities didn't accept expert advice.

MR. McMASTER: That is not our recommendation in any event. I think actually the law, if it ultimately becomes the law, it should be written in such a manner that

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expert advice would be taken by government. I realize that it is easy to change the schemes in your mind. It is not easy to get them in practise. There would have to be some adjustments.

COMMISSIONER McCUTCHEON: What would you do with drugs?

MR. McMASTER: We haven't dealt with drugs here, but frankly we would apply the same system to drugs, that is we think the co-operative principle should apply. In one place we know this is being done, that is in Regina, the Sherwood Co-op is a consumer discount store which is engaged in the dispensing of drugs as well as in the sale of other things and their experience has been -- I am sorry, I haven't got the figures here. My recollection is their experience has been that the refund on drugs has been about three times the amount they could rebate on other goods they deal in. If it of interest to the Commission I am sure I could get the information with regard to the Regina experiments and file it.

THE CHAIRMAN: If you would.

MR. McMASTER: My friend, Mr. Wright, brought to my attention the fact that the social assistance branch of the government supplies drugs through the provincial dispensary and they may have some experience with regard to the question of cost.

THE CHAIRMAN: Where is the provincial dispensary?

MR. WRIGHT: As I understand that the social assistance medical division furnishes these through their pharmacy which is on Cassiar Street in Vancouver for local

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THE CHAIRMAN: Where is the provincial [illegible]

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cases.

THE CHAIRMAN: I live in Prince George. I am in receipt of social assistance. What happens to me with respect to drugs?

MR. WRIGHT: There have been some changes recently in the provision of drugs, but I understand from conversations I had with the social service medical division that special arrangements are made whereby recipients of social assistance who are entitled to drugs purchase them at the local pharmacy and the bill is sent directly to the Provincial Government.

THE CHAIRMAN: Thank you. Have you some questions Dr. Baltzan.

COMMISSIONER BALTZAN: Yes, Mr. Chairman. Mr. McMaster, page IV, paragraph 2 you refer to you consider the salary method to be the method providing the greatest control of quality. I neither question the statement nor do I want to debate it. I want one or two explanations. My first question, is the method you suggest used as a means of control of the quality, if you are going to do it by this method it will improve quality?

MR. McMASTER: I think of the three methods which we discussed in the brief, Doctor, one is payment on a fee-for-service basis, one is capitation, the method used under some national health schemes and the third is salary. We feel that the better quality would result under a salary system.

COMMISSIONER BALTZAN: That is your opinion; when this is used as a control you obtain better quality, that is the reason for your proposition?

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COMMISSIONER BALDRAN: Yes, Mr. Chairman. Mr. Monastyr, page IV, paragraph 2 you refer to you consider the salary method to be the method providing the greatest security. I assume question the statement now do I want to debate it. I want one or two explanation. My first question, is the method you suggest used as a

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MR. McMASTER: No, that may make it easier to ascertain quality. I think our position would be that a doctor adequately, a doctor, for instance, adequately compensated by salary and free from filling out forms, and freed from the necessity of operating his practics as a business would be in a better position to give better quality service, give more of his skills than if he had to trouble with operating his practice.

COMMISSIONER McCUTCHEON: How do you know he is earning his salary if he doesn't fill in documents?

MR. McMASTER: With respect, sir, I submit that there a great many in Canada who work on a salary at the present time that don't fill in forms.

THE CHAIRMAN: They have a boss looking over their shoulder.

COMMISSIONER McCUTCHEON: You have a doctor in Prince George being paid from Vancouver.

MR. McMASTER: You have to have some forms. I would make a comparison with the teaching profession where you have superintendents in the schools and you have principals and you do have some forms, I regret to say, but I think the forms become many less in a co-operative system. There are less forms than we now have.

THE CHAIRMAN: Mr. McMaster, is there any country in the free world where the medical profession is on salary?

MR. McMASTER: There are experiments, sir, what might be regarded as experiments-actually operating plans in the United States at the present time. Two of them are referred to in our brief.

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THE CHAIRMAN: On a country basis.

MR. McMASTER: On a country-wide basis, I don't think so, no, I don't believe so. I might say that the group plans in Seattle and New York State are on a salary basis and work very satisfactorily.

THE CHAIRMAN: What plan are you talking about?

MR. McMASTER: H.I.P.

THE CHAIRMAN: Capitation?

MR. McMASTER: I am sorry, I am mistaken. It is in Puget Sound in Seattle that is on salary. There is information in our brief concerning the group down there.

THE CHAIRMAN: Who collects the funds from which the salary is paid?

MR. McMASTER: The Society collects it from the members.

THE CHAIRMAN: What society are you talking about in Puget Sound?

MR. McMASTER: The Group Health of Seattle, I am informed. Again, if the Commission were interested I could get some details.

THE CHAIRMAN: That group in Seattle is a group collecting individual premiums from persons and dividing the money amongst themselves?

MR. McMASTER: No, it is a co-operative plan,sir, that is operated by the members and they hire doctors and they have their own small hospital, I believe. The thesis, it seems to me, of our proposition is from this experience of the obligation of co-operation.

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THE CHAIRMAN: How many members in Puget Sound?

MR. CORSBIE: Roughly 61,000 people covered. This was a year ago when we visited.

MR. McMASTER: That would be coverage. It doesn't answer the question of membership.

COMMISSIONER BALTZAN: Mr. McMaster, still focussing attention on the question of quality and taking your proposition as mentioned, my question is who would be the judges of quality?

MR. McMASTER: I again take the view, I think it is the view of the Society, when it comes to the professional aspects in medicine we will have no illusions, we must set up as the judges the people who are the experts in the field, who are the people who are trained, much in the same way as we are now dependent by virtue of the licensing of physicians through the physicians' own society. They would be the judges of the quality.

COMMISSIONER BALTZAN: Actually they would be in a way the controllers of the standards?

MR. McMASTER: They would continue to be.

COMMISSIONER BALTZAN: The method isn't so important as the people who are setting the standards in order to get quality.

MR. McMASTER: I think that is one aspect of it. I think the other aspect of it, if I might use an illustration, under your prepaid plan system, it seems to me that if you are paid a rate of $4.90 to go to the office and someone goes and requires attention that may take an hour, I suggest it is inadequate compensation for an hour

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COMMISSIONER BALTZAN: My question does not concern adequacy of payment. I am still speaking in terms of the element of quality and you then say that those who know the most about it will be setting the standards?

MR. McMASTER: That would be my view, sir.

COMMISSIONER BALTZAN: Would you please tell me, do you consider the present safeguards in the standards of quality not sufficiently strict?

MR. McMASTER: Through administration conducted by the doctors?

COMMISSIONER BALTZAN: Not administration, quality and standards for the kind of services produced, are the present methods of controlling and setting standards, are they sufficient or not strict enough?

MR. McMASTER: In the first place and I am caught on the horns of my first answer. I frankly say that the judges of this must be the people who are in the field of medicine and are trained in the field of medicine. For me to express an answer to that, as to their standards, I must accept them as I have no other basis than to find them satisfactory standards. I would say this from my own professional experience, it seems to me the standards of work of a person may be a better standard if he doesn't have the pressure of non-professional duties put upon him and he is free to perform only his professional duty.

COMMISSIONER BALTZAN: We won't debate that, but some people find themselves producing more under pressure

of the doctor's time. On the other hand some other person may go in and may not take very much time at all and that would be adequate compensation.

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MR. McMASTER: Yes, it depends on the kind of pressure. If the pressures are medical problems I think this would be true. If the pressure is the pressure of making your partnership a business it may not be true.

COMMISSIONER BALTZAN: Thank you very much. It was very interesting. At some time one could go into the philosophy of the profession and their reasoning of such things as control. This is not the place for it.

THE CHAIRMAN: Mr. McMaster, do you see any difference in principle in putting the physicians on a salary or practising lawyers on a salary?

MR. McMASTER: I don't see any difference in principle with the limitations that quite frequently practising lawyers, lawyers must represent conflicting interests, and therefore there becomes the difficulty if lawyers were on a salary from the State, just how this man who is paid by the State could represent conflicting interests in litigation. In terms of the quality of work which might be produced by a person practising a profession, I think this would be true, even lawyers free from operating their practices as a business, that they could practise law better. It wouldn't be a practical thing to do for the reasons that I indicated in the legal profession.

COMMISSIONER BALTZAN: Clinics do it by hiring office managers and collectors.

MR. McMASTER: I think they do to some extent, sir. I think they are able to give, in group practice, in clinics it leaves doctors freer to practise medicine without these other pressures.

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COMMISSIONER BALTZAN: With as wide application?

MR. McMASTER: Yes.

COMMISSIONER FIRESTONE: Mr. McMaster, I would like to congratulate you and your associates for the usefulness of the brief you have submitted to us. In this special Schedule 12 in which you anticipate some of the questions and provide us with answers plus many other questions we may not have asked, that is a useful document. Might I have clarification of some of the things you have said in Schedule 12. In question 1 you say that you are in favour of nationalization of all health services. What do you mean by nationalization of all health services?

MR. McMASTER: Well, I qualified that in the answer by saying in the manner and to the extent in our brief. You have to tie it in. What we say is that we would like to see a co-operative method of meeting problems extended to a national basis to include everyone rather than being limited to groups as they are now, as is the practise in the Province of British Columbia.

COMMISSIONER FIRESTONE: What do you mean by nationalization?

MR. McMASTER: That is a word, frankly, that I suppose has different meanings to different people, and it is quite correct that our minds should be applied to it. By nationalization, what I am meaning is that the problem must be attacked on a national basis as distinct from a piecemeal basis, such as we suggest exists at the present time or even, I would say, ultimately. It would not be satisfactory on just a provincial basis. It needs to be an

COMMISSIONER BARTMAN: With as wide application

would like to congratulate you and your associates for the use unions of the brief you have submitted to us. In this special Schedule 12 in which you anticipate some of the questions and provide us with answers plus many other questions we may not have asked, that is a very, very [illegible]

MR. McMASTER: Well, I qualified that in the [illegible] by saying in the manner and to the extent in our brief. You have to take it in. What we say is that we would like to see a co-operative method of meeting problems extended to a national basis to include everyone rather than being limited to groups as they are now, as is the practice in the Province of British Columbia.

COMMISSIONER FIRESTONE: What do you mean by nationalization?

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integrated programme on a national basis.

COMMISSIONER FIRESTONE: When you speak of nationalization, you are really referring to a national plan or programme?

MR. McMASTER: That is right.

COMMISSIONER FIRESTONE: And you would accept the facts of our constitutional life in saying that the national programme while initiated nationally would perhaps most properly be administered provincially in line with our constitutional division of responsibility?

MR. McMASTER: Yes, both constitutionally, geographically, and also the desirability of having local participation.

COMMISSIONER FIRESTONE: So, that is your view?

MR. McMASTER: Yes.

COMMISSIONER FIRESTONE: Now, referring to paragraph 24 on page 10 of your Schedule 12, would you be in favour of a national health plan such as you envisage to come into effect as and when the majority of people were prepared to participate in such a plan following the pattern that has been established in introducing the health insurance programme in Canada?

MR. McMASTER: I think, in answer to the question, that I would enlarge on that, again, to say that we would prefer to see it done as a wholly national thing.

On the other hand, realistically, we recognize this may be possible, and if it is not, then certainly the pattern that was generally followed with regard to hospitaliza- would appear to be the realistic one.

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COMMISSIONER FIRESTONE: My next question refers to question 31 on page 15. Realizing that the resources available to Canada are limited, the resources available for any purpose and the resources available for health purposes, what would be your first priority in developing a national health programme?

MR. McMASTER: Well, I would, and I think the Society would, sir, suggest that there is a necessity to proceed on the four fronts which I have set forth there, and to proceed concurrently on this. I say that we can get into the kind of argument, if you are going to give assistance to an under-developed country, do you feed the people or give them medical assistance, or do you do both, and do you help them build their economy. And it does seem to us that the four things we have mentioned there are basic things, where some progress ought to be made on all four fronts at the same time. The same kind of progress may not be possible but an intention to proceed in this way in our view is the minimum programme.

COMMISSIONER FIRESTONE: Within those four areas, are there some areas perhaps more important than others, which you would list first and some second? In what order would you consider a priority to be appropriate?

MR. McMASTER: I think we would be inclined to say that they need to proceed together. In other words, they are complementary to each other, and being complementary to each other that to proceed on one, even on a grand scale, and to avoid the others would be to defeat your ultimate end and that, therefore, even if you have to proceed on a small scale it would be better to proceed

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on all four fronts than it would be to go off on one.

COMMISSIONER FIRESTONE: Would you then list the four fronts?

MR. McMASTER: The four fronts are broad medical coverage for every individual and, as we say, we suggested when you have that you then get the foundation of information for research and planning and many other things.

In educational fields, to provide needed dentists, particularly, and other healing arts, planning to co-ordinate present facilities of a voluntary and public nature that are available in society, and finally research and rehabilitation programmes which would be designed -- preferably the ones most likely to bring social and economic benefits.

COMMISSIONER FIRESTONE: Thank you very much, Mr. McMaster.

I am turning now to your main submission, recommendation number 1 on page IV your first point is, and I quote:

"A national health program must provide "comprehensive health care for all citizens "without regard to means."

I take it comprehensive covers preventive, diagnostic, general medical care, surgery, rehabilitation?

MR. McMASTER: Yes.

COMMISSIONER FIRESTONE: And related services?

MR. McMASTER: In related services, yes, and some of the other healing arts also.

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COMMISSIONER FIRESTONE: Some of the other healing arts?

MR. McMASTER: Yes.

COMMISSIONER FIRESTONE: It covers both physical and mental health?

MR. McMASTER: Yes, sir.

COMMISSIONER FIRESTONE: You say, further, in this province the scheme should be contributed to by all citizens and its benefits should be available to all who wish to avail themselves of it.

How would you define contributed to by all citizens? Do you have in mind paying for it in taxes, through premiums, or a combination of these two methods?

MR. McMASTER: I have I think later in our recommendations that we recommend three approaches to the cost. One is that we feel that there should be co-insurance of some kind, partly as a contribution to the cost and partly as a deterrent.

Further, that there must be some money expended from the public taxes, perhaps even in excess of the ability of society at the moment to produce well. There may have to be a re-apportioning of values in this regard.

Finally, that it can be met in part by amortizing the cost through the issue of health bonds and amortizing these costs over a period of time that you would be able to recuperate much of the cost through the saving through better health.

COMMISSIONER FIRESTONE: This proposal of the government issuing health bonds is a new proposal to us. We are obliged to you for coming forward with new ideas.

COMMISSIONER FIRESTONE: Some of the other

physical and mental health?

MR. MONAGHAN: Yes, sir.

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COMMISSIONER FIRESTONE: This proposal of the government issuing health bonds is a new proposal to us. We are obliged to you for coming forward with new ideas.

Could you explain to us what these health bonds would cover? Are you planning for these bonds to cover capital expenditures of the plan, operating expenditures, a portion of the expenditures incurred? What are you planning for those health bonds to cover?

MR. McMASTER: Well, I think you would have to take your total initial cost, some of which would be capital and some of which would not be, and some factors of which must be met immediately in immediate expenses, some of which may be spread over a period of time.

THE CHAIRMAN: What do you visualize as the period of time?

MR. McMASTER: I visualize the period of time -- I think we are inconsistent in our brief. I have in one place 25 to 50 years, and in another place 50 to 100 years.

My own feeling is simply in the neighbourhood of 50 years would be the period of time in which we could expect to recuperate from some plan, and rehabilitation efforts in health care that we could expect to reap the benefits of those policies, and if we come to reap the benefits of those policies in better incomes, more people being able to work who otherwise would not be able to, then naturally we are going to increase the ability of the economy to meet with initial expense.

THE CHAIRMAN: You are suggesting the issuing of bonds every year?

MR. McMASTER: No, my suggestion is at the outset of the programme you would issue bonds.

THE CHAIRMAN: And you would have enough

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THE CHAIRMAN: And you would have enough

money for 50 years?

MR. McMASTER: No, not enough for 50 years, sir. Enough money to initiate your programme. This initiation period might be a period of several years. I do not imagine it could all be done at once, but your basic costs -- we are going to add to the total cost of health in this country, if we do it all at once or if we do it in a short period. Some of that cost, I am saying, is properly spread to the future, because you can recover it.

THE CHAIRMAN: How can you spread to the future the salary to pay to the doctors today, tomorrow and next month?

MR. McMASTER: I do not think your basic problem is the salary you are going to pay the doctor. I think that is going to be met out of the same sources that we now pay the doctor, but we will re-distribute them in a little different way. But you are going to have instances in terms of education, in terms of research, in terms of rehabilitation programmes, in terms of buildings and capital investment that you have to have now and which will serve the community for a period of 50 years, and if they serve the community properly it should result in savings that should pay for this.

We have given as examples and they are just examples what was done with tuberculosis, for instance, in this province particularly, and in some other diseases elsewhere, where the saving in people working and people rehabilitated, aside from the human factor, has truly compensated for the initial expense that we made.

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COMMISSIONER McCUTCHEON: You must pay for expropriating the doctors' equipment.

MR. McMASTER: Yes, if it were expropriated.

COMMISSIONER McCUTCHEON: And taking over his leases.

MR. McMASTER: The doctor would be reasonably compensated.

THE CHAIRMAN: Would you give the doctor a little better treatment than you gave the hospital? We did not pay back; we just commandeered the hospitals.

MR. McMASTER: I do not think we have quite done that with the hospitals. My friend, Mr. Black, is quite familiar with the hospitalization in British Columbia. Perhaps he would like to comment with regard to that.

THE CHAIRMAN: The hospital was in operation, and the legislation is that now a patient goes into the hospital and there is no debtor or creditor relationship left between the hospital and patient when he leaves the hospital?

MR. BLACK: That is, there is no relationship between the patient and hospital as far as credit is concerned?

THE CHAIRMAN: Yes, debtor and creditor relationship.

MR. BLACK: This may be so. In British Columbia, we have a co-operative effort where there is a minimum charge of $1.00.

THE CHAIRMAN: There was a building standing of $5 million ---

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THE CHAIRMAN: There was a building standing of $3 million ---

MR. BLACK: That is right.

THE CHAIRMAN: The plan was put into operation, and they said, "That is where you are going to get your hospitalization", without any responsibility to the person who put it up.

MR. BLACK: The Vancouver General is the largest hospital in the metropolitan area. It is a community-owned hospital for the City of Vancouver and the citizens of the City of Vancouver. In St. Paul's, a large institution within the orbit of the City of Vancouver, it is owned by that particular religious order, and they have now been relieved of a great deal of responsibility because today through the pooling of resources, their pick-up and their operation is taken care of.

Without being presumptious, I would say that the people of the Province of British Columbia would not be without the hospitalization scheme which we have in operation in this province today.

COMMISSIONER BALTZAN: Are these hospitals in a good credit position? Or, are they in the hole?

MR. BLACK: In the hole?

I would say, relatively speaking, our hospitals are better off today financially than they ever were at any time in their history. And they are providing better services to our citizens. And they have relieved the people of the Province of British Columbia of terrific responsibilities.

COMMISSIONER BALTZAN: You believe that the people are satisfied?

MR. BLACK: I claim -- I think it is my

1 considered opinion that this is one of the best services
2 on the North American continent.
3 COMMISSIONER BALTZAN: Do they complain very
4 much about not being able to get into the hospital and
5 get out of the hospital faster than before?
6 MR. BLACK: There have been some complaints
7 about not getting into the hospital, but with the building
8 of new acute beds every day, I think this situation is
9 being alleviated.
10 Naturally, when this scheme first went into
11 operation, there was a great demand for hospitalization,
12 but with the new addition and the adding of beds, I think
13 this condition is being gradually overcome.
14 COMMISSIONER BALTZAN: And these costs for
15 the new additions are being adequately met?
16 MR. BLACK: Well, we get into, again, some
17 discussion as to adequacy.
18 COMMISSIONER BALTZAN: I just want to learn
19 from you.
20 MR. BLACK: They are being met. I would say
21 I am privileged, sir, to bargain on behalf of all the
22 employees in the Province of British Columbia with roughly
23 about 45 of our acute general hospitals, and I know that
24 my position in relation to the hospitals is much different
25 now than it was, shall we say, ten years or fourteen years
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The hospitals today are giving much greater service to the patients and general public than they did a

any time in their history. That is, in diagnostic care, laboratory care; you name it and today we have it in the hospital service.

I do not know where in the North American continent you can go for $1.00 per day and get lab service, x-ray service, diagnostic care, hosptial care.

THE CHAIRMAN: The Province of Manitoba for no dollars.

MR. McMASTER: They are giving it away! I know that is said, I am not ---

THE CHAIRMAN: We are not going to argue anything now; you can leave off the labour speech and we will get on with the questions.

COMMISSIONER FIRESTONE: Mr. McMaster, turning to recommendation 3 on page IV. You say and I quote:

"Encouragement should be given to group "practice among those engaged in the healing "arts and sciences."

What kind of encouragement do you have in mind?

MR. McMASTER: Well, I think encouragement in terms of -- if the doctors were on salaries, the encouragement would be in making available the kind of facilities that would encourage group practice.

COMMISSIONER FIRESTONE: Such as?

MR. McMASTER: Such as facilities which were suited for the proper seeing of patients; providing of facilities in the group practice for x-ray, some with rehabilitation, and this sort of thing. The sort of things it is difficult for a doctor in individual practice to

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provide, and where he must rely upon the services that are made available through the community hospitals.

COMMISSIONER FIRESTONE: You would, therefore, be in favour in developing medical clinics?

MR. McMASTER: Yes.

COMMISSIONER FIRESTONE: And what are you reasons for favouring the development of medical clinics or a group of practitioners practising in one clinic?

MR. McMASTER: I think there are several reasons that enter into it.

In the first place, within the limits of size. Now, if you get too big, there are some limits to this: It is more economical.

Furthermore, I think that it provides a possibility of continuing a doctor-patient relationship and at the same time relieving the doctor from some of the pressure of the rest of work which an individual doctor is put under. There is a possibility of sharing responsibility in a manner that is satisfying to the patient as well as satisfying to the doctor. And, in the third place, I think it does make possible the provision of facilities to assist the doctor in the use of his skills close at hand which otherwise he may have to send the patient off elsewhere to have. He has associated with him, presumably, on the one hand experts, specialists each in his own field, and he may also have associated with him people in the other humanities or in other trainings such as nurses, physiotherapists, and that sort of person.

COMMISSIONER FIRESTONE: In other words, you think that such a development would be in the interest

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You think that such a development would be in the interest

of providing improved medical care and other health services?

MR. McMASTER: Yes.

COMMISSIONER FIRESTONE: And continuity of service?

MR. McMASTER: That is right.

COMMISSIONER FIRESTONE: Now, you said that one of the reasons you were in favour is because it would make a system of salaried doctors more effective. Please correct me, if I understood you correctly, you made this encouragement of group practice contingent on a system developed in Canada which would put the doctors on a salary basis?

MR. McMASTER: I am sorry, sir, that was what we recommended, a system of salary. On the other hand I don't think the development and encouragement of a group practice is conditional,upon that recommendation being accepted.

COMMISSIONER FIRESTONE: You are anticipating my next question. That was exactly the point. Thank you for being just a step ahead of the Commissioners. Thank you very much.

COMMISSIONER BALTZAN: Thank you for improving on the way I asked the same question.

COMMISSIONER McCUTCHEON: Do you visualize under your recommendation, and we will deal with the medical profession, I assume the dental profession would be the same, for instance, but we will deal with physicians. Do you visualize all the physicians being paid salaries by government at one level or another, or do you visualize some

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MR. McMASTER: I think that physicians should be allowed out of the scheme as long as the needs of the people are being attended to. In other words, if a physician wants to have a private office and there are people who want to go to him I think they should be given an opportunity, both of them, to get together in providing medical care for themselves.

COMMISSIONER McCUTCHEON: Let us take the body of physicians that are being paid salaries. How many physicians are you going to put on salary in British Columbia?

MR. McMASTER: That is a question I don't think I can answer. I would think that the main body of physicians would be enlisted on a salary basis in British Columbia if we were going to meet the medical needs of the people.

COMMISSIONER McCUTCHEON: How do you determine, let us take a class of medical students graduate in 1970, what proportion of those is the Government going to hire? Is it going to guarantee to hire everyone who comes out of medical school?

MR. McMASTER: In an overall plan I would suggest that the Government -- you can't absolutely control the flow of medical students, but the flow of medical practitioners would ultimately adjust itself to the needs of society in that regard. You might have some immediate problems, I could see, in terms of people who are now in private practice and who might prefer to remain in that kind of practice. That might present a problem. I would

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2 would adjust the flow of doctors to the needs of the
3 community.
4 COMMISSIONER McCUTCHEON: What about the
5 doctors who immigrate to this country? Will the Government
6 give them an undertaking that they will be taken on
7 salary?
8 MR. McMASTER: I think once again we would
9 be in the position where we are now with their qualifica-
10 tions, to see if they were proper.
11 COMMISSIONER McCUTCHEON: Assume they are
12 qualified.
13 MR. McMASTER: Assume that they were
14 qualified and assume there is a need for doctors.
15 COMMISSIONER McCUTCHEON: Who determines
16 the need under your scheme?
17 MR. McMASTER: It seems to me it is the
18 administrative body which must determine, that must determine
19 it, having regard to what are the facts as to people's
20 mental care, not mental, health care plus what are the
21 professional recommendations of the people who are looking
22 after that.
23 COMMISSIONER McCUTCHEON: An administrative
24 body takes that recommendation and goes to the Treasury
25 Board and says here are our estimates on next year and the
26 Treasury Board says you have to cut this by $5 million,
27 what happens at that stage? Do you let some of the doctors
28 out?
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COMMISSIONER McCUTCHEON: You could refrain from taking any more in?

MR. McMASTER: You could refrain from taking any more in and you could refrain from encouraging, on the one hand, young men from going into the profession or alternatively allowing doctors to immigrate into the country. It seems to me that you would have an opportunity to adjust.

COMMISSIONER McCUTCHEON: The decision becomes a budgetary one?

MR. McMASTER: No, I would suggest to you, sir, it isn't any more than it is in the field of education.

COMMISSIONER McCUTCHEON: It definitely is in the field of education.

MR. McMASTER: No, I respectfully submit in the field of education that we have to educate our children, and we do educate them. We may not pay adequate compensation to the teachers and there may be a time when we have a few more teachers than we have opportunities. Now, in British Columbia there have been many more oportunities to teach than there are teachers. That can vary according to the needs of the community. The thing that would have to be taken into account in any national plan is what the present rates are and are going to be in the next ten years. We need to look ahead in planning. That is part of planning in my view. It is part of looking ahead to what are the needs going to be five or ten years from now. Under a method of this sort, I would suggest it is possible to look ahead and to plan, whereas if you look at a piecemeal operation it is extremely difficult to look ahead

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at all.

COMMISSIONER McCUTCHEON: You have indicated somewhere in the brief, and I am not quoting, I am paraphrasing, that there would continue to be freedom of choice by the patient of the doctor and by the doctor of a patient, having regard, I think you said to geography.

MR. McMASTER: Geography and ethics.

COMMISSIONER McCUTCHEON: Ethics, certainly. One other factor, I have just graduated, completed my internship, passed my Dominion Council and I am ready to practise. Where are you going to put me? May I select where I practise? May I have my office in the great building across the street? Will you pay for it or will you say no, I have to go up four miles north of Prince George and you will provide me with an office there?

MR. McMASTER: I think much of this could operate much as the school is in British Columbia, where you have local school boards who actually hire teachers. You could go to Prince George for better remuneration and not quite such onerous duties but if you want to stay in Vancouver you could stay and take your chances of getting on the staff in Vancouver. I don't think anybody could guarantee anybody they are going to have an office wherever they want to have it. It has got, in some measure, to relate to the social needs of the community. If you enter private practice a doctor who sets himself up in a community that is well served isn't going to survive in private practice. This doesn't hold with lawyers. I don't think it would apply to doctors.

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more lawyers to the population than doctors.

MR. McMASTER: That is likely so.

COMMISSIONER McCUTCHEON: I come back to this, you suggest in your brief, and again I am paraphrasing, there must be a legal obligation imposed on the doctor and you quote the Act of 1936, I think it is, to render service as directed by the State. Surely that means, if that means anything, it means he has got to render it where you want him to, when you want him to and whatever figure you are prepared to pay him?

MR. McMASTER: With respect, sir, that is dealt with in the questions. I wonder if Mr. Wright could find that.

COMMISSIONER McCUTCHEON: You suggest the doctors are going to co-operate?

MR. McMASTER: What we say, and it is question 23 that was proposed in the statute which is put on the books.

COMMISSIONER McCUTCHEON: That is right.

MR. McMASTER: However, we do say, we suppose from the legal point of view if you are going to write the statute you have to have the corollarly of some sanctions. Frankly on the basis of the good reputation which the doctors have had in the service of the community at the present time I don't anticipate, nor does the Society anticipate that we need be concerned with more than the legal necessity of having something in the statutes. I would think that from past performance that the doctors who have set this high standard, and I think they stay by that high standard generally, would respond to the needs

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and desires of the community.

COMMISSIONER McCUTCHEON: Thank you very much.

THE CHAIRMAN: In the matter of planning, would you visualize there would have to be 20 or 30 years' after it started, there would have to be a plan so that sufficient students would offer themselves for medicine?

MR. McMASTER: You have to plan an educational programme in that we would encourage young men of competence, young men and young women of competence to look on this as a desirable place to serve.

THE CHAIRMAN: You have the need for 500 doctors or a thousand, or whatever the figure might be and you would have to do more than just make some pious suggestions. How would you direct them into the study of medicine to get the thousand graduates?

MR. McMASTER: I don't think, sir, you would have to drag them. I think there are several ways you can do this that are well known now. If you make the remuneration attractive when you are through, if you make the study available to young men and young women of ability.

THE CHAIRMAN: You are hanging a carrot out in front.

MR. McMASTER: Not only in front, but an immediate carrot that they can reach.

THE CHAIRMAN: Take a nibble at it as they go along. This is going to attract the doctors you want. Supposing it is so attractive that you get too many?

MR. McMASTER: Then you must remove the carrot.

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MR. MCMASTER: Then you must remove the barrel.

COMMISSIONER FIRESTONE: Or make it smaller.

MR. McMASTER: Or make it smaller.

THE CHAIRMAN: In other words you would have to move into every other field in the educational field?

MR. McMASTER: In relation to health, yes. Again I think you only have to look at this in relation to education at the present time.

MR. McCUTCHEON: In the universities?

MR. McMASTER: In our own universities, yes, I think of loans and bursaries which are available now in education that did not used to be available. Teachers' salaries are better than they used to be, much better than they used to be. The results are reflected in the increasing number of students taking education at the University of British Columbia.

COMMISSIONER VAN WART: Mr. Chairman, in Schedule number 12, page 2, number 5, the question is: What would become of voluntary agencies and provincial health programmes. Then you answer in three parts. What I am interested in at the present time is A, these should be continued to be encouraged to meet local needs and interests and to involve people in their responsibilities for the health of their communities. At the present time you operate voluntary schemes, do you not?

MR. McMASTER: Yes, our Society operates a voluntary scheme.

COMMISSIONER VAN WART: How are the doctors paid under that scheme?

MR. McMASTER: They are paid on a fee-for-

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MR. McMASTER: Yes, our Society operates a voluntary scheme.

COMMISSIONER VAN WART: How are the doctors paid under that scheme?

MR. McMASTER: They are paid on a fee-for-

service basis through an arrangement with the Canadian Medical Association, B. C. Division.

COMMISSIONER VAN WART: Are you having any difficulties or criticisms at the present time of the method of payment?

MR. McMASTER: Mr. Corsbie, you are the manager.

MR. CORSBIE: We have what we call problem claims where the claims are higher than they should be.

COMMISSIONER VAN WART: You mean from the doctor's point of view?

MR. CORSBIE: Yes, a very small percentage, mind you.

COMMISSIONER VAN WART: Would there be a larger amount than you would expect in the operation of any business?

MR. CORSBIE: I don't know what kind of answer I could give to that. I don't know what you expect in business. I expect all business to be honest.

COMMISSIONER VAN WART: There are always some people in very group you have trouble with.

MR. CORSBIE: I don't think we get more than you could expect in the way of problem claims. It is a small percentage that do, over-service, over-billing and so on.

COMMISSIONER VAN WART: Outside of easier administration would you see any advantages in introducing salary to these doctors at the present time?

MR. McMASTER: I think this is the thesis of our brief. I think in part, at least, we have tried in the body of the brief and in the supplementary material to suggest that there would be something to be gained from the standpoint of society introducing this method.

difficulties or criticisms of the present time of the method of payment?

Mr. MURDOCK: Mr. Doctor, you are the representative.

Mr. COGGER: We have what is a real problem claims where the claims are higher than they should be.

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Mr. COGGER: Yes a very small percentage, mind you.

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Mr. MURDOCK: I think this is the crux of the brief. I think in part, at least, we have tried in the body of the brief and in the supplementary memorandum to suggest that there would be something to be gained from the

[redacted]: It is not a method that, apparently, at the moment has been a subject of discussion in the Medical Association or one which they in other parts of the country have shown themselves very enthusiastic about. Therefore, as far as the Society operation is concerned it ties into the plan of pre-paid health in this province and it is one of several groups and that is the basis of payment.

COMMISSIONER VAN WART: Do you think the present system of administration as it is operated is detrimental to the quality of medical care given?

MR. McMASTER: I suggested that I think that the quality of the medical care could be improved if the doctor is free from the pressure of operating his practice as a business and he must do it under this pre-paid plan. He has got to keep his billing up and get his collections in and fill in forms and so on and if he could be freed from this, whatever method is used to free him, he can apply his skills better for what he is trained for, and in that sense improve quality.

COMMISSIONER VAN WART: Have the doctors stated to you that that would be a fact?

MR. McMASTER: I think the doctors, frankly, I am speaking for myself -- I shouldn't do this, I am here representing the Society -- my feeling, sir, if you are interested is that the doctors are over anxious and concerned about the possibility of what they describe as socialized medicine. For this reason sometimes it is difficult to discuss with them something which in my mind is not all the bogey they are thinking of.

in the Medical [illegible]

board of the [illegible]

about. Therefore, [illegible]

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[illegible]

THE CHAIRMAN: You mean socialism is not a bogey to socialists?

MR. McMASTER: I suggest, sir, that is probably true, but on the other hand we all have different ideas as to what socialism is.

COMMISSIONER VAN WART: All I am getting at, is it your opinion if you changed your voluntary people at the present time from fee-for-service to a salary, you say the quality of the medical care would be better?

MR. McMASTER: I would say from the doctor's point of view.

COMMISSIONER VAN WART: From your point of view, what do you think?

MR. McMASTER: Yes, from everybody's point of view. It would be possible for the doctors to give a better quality of medical care if they were freed from the pressures of operating their practices as a business.

COMMISSIONER VAN WART: Your answer is based on the assumption making out forms deteriorates the quality of the medical care?

MR. McMASTER: It takes time.

THE CHAIRMAN: Hiring of a competent staff changes the quality of care?

COMMISSIONER VAN WART: All I want is your argument.

MR. McMASTER: I don't want to carry on an argument. I think if a person who is pressured can be guaranteed, if he can be relieved, there may be various ways, of the pressure of carrying on a business of all the bureaucracy, filling in forms, he is free to practise

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MR. MONASTER: I think so.

THE CHAIRMAN: Mr. [illegible] a supplement which [illegible] the quality of care?

COMMISSIONER VAN WART: [illegible]

MR. MONASTER: I don't want to carry on a [illegible]. I think if a person who is [illegible] can be successful, if he can be rehabilitated, there may be various ways of the problems of carrying on a business of all the [illegible]

the thing he is qualified for. There may be other ways of freeing the doctor from these kind of pressures. If there are they should be explored. We put forward this one.

COMMISSIONER VAN WART: Your argument is based on the assumption these things interfere with the quality of medical care?

MR. McMASTER: I suppose, if I have to put a negative statement. I would put it on a positive basis, that a better quality can be performed if the doctor can be relieved of these pressures.

COMMISSIONER VAN WART: Thank you.

COMMISSIONER STRACHAN: I presume, Mr. McMaster, that all education in the health field, at least, would be paid for by the Government. Would you permit university graduates to go to other countries?

MR. McMASTER: I think actually that in an overall national plan that some provision for a top-flight student to go elsewhere for study where they have facilities to train people that we don't have in this country would be sound planning.

COMMISSIONER STRACHAN: I mean just to leave the country to practise elsewhere?

MR. McMASTER: I think you would have to let them, sir.

COMMISSIONER STRACHAN: You have suggested that health personnel should relate to social needs. I rather repeat the question of the Chairman, shouldn't lawyers be forced to so do, and everybody else, all citizens?

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COMMISSIONER STRACHAN: I presume, Dr. McMaster, that all education in the health field at least would be paid for by the Government. Would you support an overall program to go to other countries?

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COMMISSIONER STRACHAN: You have suggested that medical personnel should relate to social needs. I

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MR. McMASTER: I think in a greater or lesser degree all citizens are. I suggest that the professional people now are geared to the social need. Now, what happens at the moment, however, is that are they as closely geared to the social need as is desirable, or as could be done under a scheme that people would be willing to operate under?

COMMISSIONER STRACHAN: You are going to gear the social need of the health professions by a salary. Why should not everybody else be on a salary?

MR. McMASTER: As I say, a great many people are on salary in this country now, including a great many doctors. I think that there may be some distinction as far as my own profession is concerned, although as far as I am personally concerned, I would be very happy to be on salary and not to have the worry of operating a business.

COMMISSIONER STRACHAN: I am just wondering if I am not encouraged by the salary idea, because I must admit that some days I get terrifically tired in the afternoon, and I would like to quit, but because I have to make a living for my family and myself, I am forced to carry on.

Then, may I ask what hours, if I were on that salary, what hours you would expect me and my medical confreres to work during a day, and what days we would have off, and so on?

MR. McMASTER: I can only say this from my own experience in the practise of law, sir, that I think that from six to eight hours a day is as much as you can reasonably expect from a person who is putting as much creativity into his work as a professional person does.

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MR. MCMAHTER: I can only say this from my own experience in the practice of law, sir, that I think reasonably expect from a person who is putting as much energy into his work as a professional person does.

Many doctors presently are required to put in a great many more hours than that, and so are many lawyers, and I am not sure it is good for creative work nor am I sure that it is good for their own health.

COMMISSIONER STRACHAN: What about acute cases that need medical care during the other sixteen hours?

MR. McMASTER: That is one of the advantages in group practice. It is true those have to be provided for; you cannot have a three-shift operation, I do not think, but you can have at least a sharing of responsibility in group practice for people needing emergency care. And you can have the sharing by a group of doctors in whom the patient has confidence, and who he wants to associate himself with.

COMMISSIONER STRACHAN: One more question, sir, that I would like to have answered.

As you have stated, this would improve the standard of medical services. Do you think it would also apply to dentistry?

MR. McMASTER: I think it would, but mind you I think there is an extremely difficult problem with regard to dentists in this country in view of the tremendous shortage of dentists.

COMMISSIONER STRACHAN: Regardless of the shortage, could you tell me how you would control either the standard of work or the amount of work done by a dentist in a day or in a year?

MR. McMASTER: I would expect that the dental profession would be the proper people to and would be able to control that.

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MR. MCMASTER: I would expect that the dentistry profession would be the proper people to and would be able to control that.

COMMISSIONER STRACHAN: I would suggest, Mr. McMaster, without going into an argument, that no one could stand even at my side and tell me what I was doing in a mouth, let alone judge afterwards. I could either do one of three things: I could work haphazardly, carelessly, and not caring whether my work lasted for a day, a week or more. Or, I could become very idealistic and render a very superior type of service to a very limited number. Who is going to decide?

MR. McMASTER: Well, with respect, I suggest I am not as familiar, perhaps, as I might be with the Dental Association, but I would think that they do establish standards now, and that they are responsible for those standards, and that they would continue. The professional person, it depends on his individual abilities and his response but, generally speaking, the quality of people in the profession is such that I would not expect them to be sold on a scheme in order to take advantage of it.

THE CHAIRMAN: Very well, gentlemen, thank you.

The British Columbia Federation of Labour.

---EXHIBIT NO. 169: Submission of the B. C. Federation of Labour.

COMMISSIONER STRAN: [illegible]

Mr. Moreton, without going into an argument, that no one could stand over my side and tell me what I was doing in a month, let alone radio broadcasting. I could never do [illegible] I could work hyperactively, personally, and not getting another my work lasted for a day, a week or more. Or, I could become very idealistic and render a very superior type of service to a very limited number, who is going to consider.

I am not in favoring, perhaps, as I might be with the Permit Association, but I would think that they do establish standards and that they are responsible for that standards, and that they work continue. The professional person, it depends on his intellectual attitude and his temperament but, generally speaking, the quality of people [illegible] be left on a service in order to take advantage of it.

THE CHAIRMAN: Very well, gentlemen. Mr. [illegible]

The British Columbia Federation of Labour.

[illegible]

Submission of the B. C. Federation of Labour.

SUBMISSION OF

THE B.C. FEDERATION OF LABOUR

APPEARANCES: Mr. Jack Moore
Mr. E. P. O'Neal
Mr. John McNevin

THE CHAIRMAN: Mr. O'Neal, perhaps before you start, I might say that we had hoped to make progress this morning, as we had a little extra time, and you suffered for it, because you were drawn back an hour.

MR. O'NEAL: I hope we do not make anyone else suffer, Mr. Chairman.

THE CHAIRMAN: I just mention to you that is how the thing arose.

MR. O'NEAL: We understand perfectly well, Mr. Chairman, and we were quite interested in listening to the discussion here.

Before we proceed, Mr. Chairman, I wonder if we might give the Board a statement arising out of a brief submitted the other day and which is of particular interest to us.

THE CHAIRMAN: Who are the gentlemen associated with you?

MR. O'NEAL: Mr. Jack Moore, Vice-President of our Federation on my right, and Mr. McNevin who is Executive Assistant of the Federation.

THE CHAIRMAN: Yes. Do you wish to read it.

MR. O'NEAL: Well, I would like to give to the members of the Board a statement.

Mr. Jack Moore

you guys, I might say that we had hoped to make progress this morning, as we had a little extra time, and you suffered for it, because you were there that an hour.

MR. O'HARA: I hope we do not make trouble

THE CHAIRMAN: I just mention to you that is how the thing stood.

MR. O'HARA: We understand perfectly well, Mr. Chairman, and we were quite interested in listening to the discussion here.

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THE CHAIRMAN: Who are the gentlemen

MR. O'HARA: Mr. Jack Moore, Vice-President of our Federation on my right, and Mr. Moberly who is Executive Assistant of the Federation.

THE CHAIRMAN: Yes. Do you wish to read

MR. O'HARA: Well, I would like to give to the members of the Board a statement.

THE CHAIRMAN: If you would like to put it in the record, I think that will be very acceptable.

MR. O'NEAL: I would like to commence with this addendum, if I may, Mr. Chairman and members of the Board, and then I could read our summary and conclusions.

This is a statement in which we are vitally interested and I think it requires clarification.

The B. C. Federation of Labour wishes to compliment the Canadian Medical Association for presenting an excellent and professional analysis of their views on the matter of a comprehensive medical services plan for all Canadians from the Canadian Medical Association's viewpoint.

There are, however, some serious inaccuracies contained in the Submission which we would like to draw to the attention of the Commission. One in particular which we feel compelled to dispute appears on Page 58.

Page 58, Paragraph 192:

"Persons who qualify for social welfare benefits from the Provincial Government receive comprehensive medical care under the Social Assistance Medical Service. All persons who receive allowances under the provisions of the Provincial Social Assistance Act, Protection of Children Act, -- and those eligible under the regulations of the Social Welfare Branch of the Federal Government qualify for coverage."

We submit that this statement is incomplete and therefore inaccurate. Order In Council No. 1401 approved June 11, 1958 formed a contract between the Provincial Government and the College of Physicians and Surgeons.

I would like to commence with this situation, if I may, Mr. Chairman and members of the Board, and say I could see no necessity and duplication.

This is a situation in which we are vitally concerned and I think it requires clarification.

The P. C. Federation of Labour wishes to complimente the Canadian Medical Association for presenting an excellent and professional analysis of their views on the matter of a comprehensive medical services plan for all Canadians from the Canadian Medical Association's viewpoint.

There are, however, some serious misconceptions contained in the Submission which we would like to draw to the attention of the Commission. One in particular which we feel compelled to illustrate appears on Page 5 and Page 56. Paragraph 1:

"Persons who qualify for social welfare benefits from the Provincial Government receive comprehensive medical care under the Social Assistance Medical Service. All persons who receive benefits under the provisions of the Provincial Social Assistance Act, Protection of Children Act, -- are those eligible under the regulations of the Social Welfare Branch of the Federal Government qualify for coverage."

We submit that this statement is misconceive and therefore inaccurate. Order in Council No. 1101 approved June 11, 1958 formed a contract between the Provincial Government and the College of Physicians and Surgeons.

This contract provides medical service for social assistance cases only if these cases have been on social assistance for three months or longer. Those on social assistance for under three months, therefore, receive no coverage whatsoever. Thousands of citizens in British Columbia are therefore excluded from coverage under this contract.

There is also the matter of unemployed employables receiving social assistance who are also excluded by Government regulations. The exclusion of this category is confirmed by a letter signed by the Deputy Minister of Social Welfare and directed to all Regional Administrators of Social Welfare on January 13, 1961. The letter reads as follows:

"Effective immediately health service benefits will not be made available to unemployed employable persons. Present holders of active health service identity cards will receive benefits until social assistance allowances are discontinued. However, no new or re-instating cards are to be issued to this category. Please convey this information to all Municipal and Provincial Offices."

Since we have been actively involved in attempting to have these matters corrected legislatively and are keenly aware of the situation, we felt compelled to bring this matter to the Commission's attention.

Respectfully submitted on behalf of

THE B. C. FEDERATION OF LABOUR

E. P. O'Neal, Secretary-Treasurer.

Now, we go to the summary and conclusion.

assistance cases only if these cases have been on social assistance for under three months, there are, receive no coverage whatsoever. Thousands of citizens in British Columbia are therefore excluded from coverage under this contract.

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Since we have been actively involved in [illegible] and are keenly aware of the situation, we feel compelled to bring this matter to the Commission's attention.

Respectfully submitted on behalf of

B. C. FEDERATION OF LABOUR

[illegible]

Now, we go to the summary and conclusion.

SUMMARY AND CONCLUSION:

The B. C. Federation of Labour most strongly advocates that there be established in Canada a comprehensive health service, designed to secure improvement in the physical and mental health of all Canadians, and to provide universal health services for the prevention, diagnosis and treatment of illness. Health services of every kind, and of the highest possible quality, should be readily available to everyone who needs them.

There is no suggestion that the introduction of new health services should mean a complete break with the past. All favourable aspects of the existing services should be absorbed into new schemes.

We submit that the existing services require strengthening and expansion, in order that benefits presently available only to insured persons, charity cases, or those who can afford to pay for them can be made available to every Canadian under a uniform service and cost structure.

And, then, we go into mental health services on the back, Mr. Chairman. I will also deal with our summary and conclusion on the last page.

SUMMARY AND CONCLUSION:

As stated in the Survey of Mental Health Needs and Resources, British Columbia has that basic structure and system for finding medical care which is necessary to develop a new approach to financing psychiatric services. It is highly desirable to carefully explore the

The B. C. Federation of Labour most strongly advocates that there be established in Canada a comprehensive health service, designed to secure improvement in the physical and mental health of all Canadians, and to provide adequate health care for the prevention, diagnosis and treatment of illness, [illegible] services of every kind and of the highest possible quality, [illegible] to every [illegible] of Canada who needs them.

[illegible] should be classified into two groups.

[illegible]

[illegible] able to cover [illegible] services and cost [illegible]

[illegible] medical services [illegible] I will also deal with [illegible] of the last page.

SUMMARY AND CONCLUSION

[illegible]

possibility of completely overhauling the system in British Columbia in order to depauperize the patient, improve individualization of care, and upgrade psychiatric care throughout the province. [10] The same might be said for all areas of mental health services in British Columbia.

The present complex of facilities in the lower mainland would appear to be more suitable for chronic or long term patients, while a fresh approach involving decentralization of psychiatric services into every community hospital in the province would help to prevent the institutional psychosis of central confinement in addition to allowing the social and rehabilitative advantages of community integration.

Increased professional and technical staff, adequately trained or educated, well paid, and working under good conditions and strong leadersh p, along with improved and community integrated facilities, would have far reaching effects in solving many of the complex problems of mental health that affect one out of every ten Canadians at some period of his life.

Mental health is a national problem and therefore it can only be effectively dealt with on a national scale. The participation of all three levels of government is essential to successful development of mental health services, and increased federal and provincial financial aid is of paramount importance to the improvement of mental health services in our communities.

The B. C. Federation of Labour appreciates this opportunity of presenting our views on this important matter to the Royal Commission on Health Services in Canada.

possibility of [illegible]

[illegible], in order to decentralize the position, improve [illegible]

[illegible]

areas of rural health services in British Columbia.

The present condition of facilities in the lower mainland, which appear to be more suitable for one or two, rather than [illegible], while a great expansion into other [illegible] in British Columbia seems into error, commonly [illegible] in the province would help to prevent the [illegible] possibility of critical concentrations in addition to allowing the social and administrative advantages of community integration.

Adequately trained o [illegible], well paid, and working under good conditions and strong leadership [illegible], [illegible] and [illegible] decentralized facilities, would have [illegible] attracting effects in solving many of the [illegible] problems of [illegible] health care, given the [illegible] assurance of good period of air life.

[illegible] health is a national problem and therefore it can only be effectively dealt with on a national basis. The [illegible] of all three levels of government is essential to a [illegible] development of health services, and [illegible] [illegible] [illegible] of [illegible] to the improvement of [illegible] health services in our [illegible].

The B. C. Federation of Labour appreciates the [illegible] to the Royal Commission on Health Services in [illegible]

The recommendations contained in the Submission are, in our opinion, minimal requirements that must immediately be implemented if Canadians are to enjoy health services comparable to that presently existing in most modern countries. We believe that no longer can we regard ill health as a misfortune to be pitied or indeed as a condition to be tolerated by any intelligent government, while the necessary resources exist to provide the highest possible standard of health care for the Canadian people.

Mr. Chairman, there is one omission. I would like to read this into the record. It occurs on page 1:

"MEANING AND SCOPE OF HEALTH SERVICES:

We intend to adhere to the concept of a comprehensive public health program that gives the broadest possible meaning to health services. By "comprehensive" is meant the full range of services and facilities that fall within the broad spectrum of health care. Preventative and diagnostic treatment, as well as curative and rehabilitative services by physicians, surgeons, dentists, eye specialists, and other specialists are included in our concept of satisfactory health services. Within the range of facilities are included hospital and specialist services to provide all forms of care and treatment for both in-patients and out-patients, dental care and facilities, opthalmic services, drug, pharmaceutical and appliance provisions (at cost) chiropratic treatment, public health services, medico-social work, rehabilitative treatment and mental health care.

implemented if Canadians are to enjoy health services comparable to that generally existing in most modern countries. We believe that no longer can we regard ill health as a misfortune to be pitied or indeed as a condition to be relieved by a "merciful government", while the necessary private order to provide the highest possible standard of health care for the Canadian people.

In Canada, there is one solution. I would like to read this into the record. It comes on

"MANDATORY PUBLIC HEALTH INSURANCE.

We intend to address ourselves to the consideration of a comprehensive public health program that gives the Canadian people assurance to be in a position, in comprehensive" in means the full range of services and facilities that will within the broad spectrum of health care. Preventative and diagnostic treatment as well as curative and

rehabilitation, and other specialties are included in our concept of mandatory health services. Within the [illegible] we provide a level of care and treatment for both in-patients and out-patients, dental care and [illegible], operative services, drugs, pharmaceutical and appliances [illegible] medical interpretive treatment, public health services, medical social work, rehabilitation, home care and

THE CHAIRMAN: Now, Mr. O'Neal, would you in your own language, as you see fit, tell us what your Federation proposes in the way of a health programme?

MR. O'NEAL: First, of course, Mr. Chairman and members of the Commission, the principle as we see it should be that every Canadian, whether they can afford it or not, should have the kind of health care, and I have listed them as diagnostic, preventive care, if they need it, when they need it, and their station in life or finances should not be the criterion.

We recognize, Mr. Chairman, that there are a lot of schemes and that these do provide a limited amount of coverage.

It seems to us that there are, I suppose, three groups of people who do not fit into those schemes. There are people who cannot afford to fit into them, who cannot afford to pay the premiums or fit into them; there are the people who can afford but do not fit into them; and, then, of course, there is the group who possibly do not bother about them at all.

Now, in order to make the scheme workable, we think the only way it can be done is on a kind of universal basis to include everyone, and then when they are in need of treatment or any kind of medical care, that they are entitled to get it; there are no barriers erected to prevent them from getting it.

THE CHAIRMAN: Without being concerned about the legal aspects of it, I mean the Dominion-Provincial relationship, and that kind of thing at the moment ---

MR. O'NEAL: They are not too good at the

moment, so we should not get into that.

THE CHAIRMAN: Just accepting what the Act says at the moment, if I am stating it correctly, what you would like to see is a programme that would be available to all Canadians?

MR. O'NEAL: Yes, that is right, Mr. Chairman.

THE CHAIRMAN: To everyone?

MR. O'NEAL: Yes.

THE CHAIRMAN: I mean, in the whole of Canada?

MR. O'NEAL: That is right.

THE CHAIRMAN: But, perhaps arrived at by degrees, or by province by province, or something like that?

MR. O'NEAL: Well, we recognize, Mr. Chairman, as do most people, I think, and sometimes wrongly, so we set out barriers at the Rockies, and we say this is B.C. here, and the Quebec people adopt a strong feeling about their boundaries, but we think that if it cannot be done immediately on a national level, that every possible encouragement should be given to it on a provincial level. By that I mean, say, if the Province of Ontario wants to go along with this, we feel it would be incorrect for some other group of provinces to try to block them from proceeding with this.

THE CHAIRMAN: Now, finances are always an important thing in any programme, and assuming that the money might be available from a dominion and provincial source, do you contemplate that there should be any premium

or contribution by the individual towards the financing of a programme? Or, is it your position that it should come wholly from taxes?

MR. O'NEAL: Well, we would like to see it come from taxes wholly, Mr. Chairman, but we recognize that in line with good, probably, economic planning that some consideration should be given probably as to how you graduate these taxes.

In other words, we should say a person who makes $50,000. a year should pay a little more than somebody making only $2,000. a year.

I think these are matters which require study and I would be hesitant to say precisely how it should be done, because I am quite sure that the economists, the administrators and politicians would have a lot of trouble finding a common ground on it.

The main concept should be that it be done to provide the best kind of medical care programme, however it is done.

THE CHAIRMAN: But we come to the practicalities of the situation. Does the Federation favour, or not, the premium system as distinct from the premium plus tax system of payment?

MR. O'NEAL: We would favour a premium system for those people who can afford to pay.

THE CHAIRMAN: And for those who are unable to pay?

MR. O'NEAL: Then, we think they should be included.

THE CHAIRMAN: The premium should be paid

or contribution by the individuals towards the financing of a programme? Or, is it your position that it should come wholly from taxes?

MR. CURRIE: Well, we would like to see it come from taxes wholly. Mr. Chairman, but we recognize that it lies with good, probably, economic planning that some consideration should be given probably as to how you produce these taxes.

In other words, we should say a person who makes $60,000 a year should pay a little more than somebody making only $4,000 a year.

I think these are certainly moral principles and I would be hesitant to say precisely how it should be done, because I am quite sure that the economists, the administrators and politicians would have a lot of trouble finding a common ground on it.

The main concept should be that it be done to provide the best kind of medical care for everyone, however it is done.

THE CHAIRMAN: But to date in the practical-ity of the situation, does the Saskatchewan Plan, or not the premium portion at distinct from the premium plus tax system, do that?

Mr. Gilbert: We would impose a premium system for those people who can afford to pay.

THE CHAIRMAN: And for those who are unable

Mr. CURRIE: Then, of course they should be

THE CHAIRMAN: The premium should be paid

for them?

MR. O'NEAL: From the consolidated revenue.

THE CHAIRMAN: Or, from whatever source the funds for the programme were being made available?

MR. O'NEAL: That is right, Mr. Chairman.

THE CHAIRMAN: What is your view, if you have one, on whether everybody should be compelled to participate in this programme or not, or whether it should be on a voluntary basis?

MR. O'NEAL: Well, I would say this, Mr. Chairman, my own view is ---

THE CHAIRMAN: No, the view of your organization, if you have one. If not, we will accept yours as an individual view.

MR. O'NEAL: That it would be compulsory, and by compulsory I mean that it would be so sensible and so attractive that -- I mean, you hate regimenting people.

THE CHAIRMAN: Well, compulsory means that we have to do it.

MR. O'NEAL: That is right. Well, you had to pay the premium; whether you wanted to avail yourself of the service or not is another matter.

THE CHAIRMAN: On this premium basis, that everybody would have to pay the premium?

MR. O'NEAL: That is right.

THE CHAIRMAN: Whether they are going to accept the service or not?

MR. O'NEAL: That is true; the same as income tax.

COMMISSIONER McCUTCHEON: What service do you

MR. CHAPPLE: From the consolidated revenue

THE CHAIRMAN: Or, from whatever source the funds for the programme were being made available

MR. [illegible]: That is right, Mr. Chairman.

THE CHAIRMAN: What is your view, if you have one, as to whether everybody should be compelled to participate in this programme or not, or whether it should be a voluntary matter?

MR. O'HAI: Well, I would say this, Mr. Chairman, my own view is ---

THE CHAIRMAN: No, the view of your organization, if you have one. If not we will accept your as an individual view.

MR. O'HAI: That it would be compulsory, and by compulsory I mean that it would be so unlikely and so [illegible] -- I mean, you have registering people

THE CHAIRMAN: Well, compulsory means that we make it.

MR. O'HAI: That is right. Well, you and [illegible] probably whether you wished to vote yourself of the service or not in another matter

THE CHAIRMAN: On this premise basis, then you would have to pay the premium?

MR. O'HAI: That is right.

THE CHAIRMAN: Whether they are going to [illegible] the service or not.

MR. O'HAI: That is [illegible] to make as

get from that?

THE CHAIRMAN: Now, then, has your Federation a view to express as to another phase of cost, and that is whether there should be what is called utilization fee or a deterrent fee, whichever you wish to call it?

MR. O'NEAL: Well, on that point, Mr. Chairman, there are several schools of thought on it. We would favour a deterrent fee providing that it was not a fee which deterred poor people who needed it from using the service.

THE CHAIRMAN: You have the dollar a day hospitalization fee in British Columbia now?

MR. O'NEAL: That is right, and we have no particular objection to that, Mr. Chairman.

THE CHAIRMAN: Alberta has $2.00 a day. I do not know of any other province that has any more.

MR. O'NEAL: What we have in mind is something to prevent people from being frivolous about this thing and abusing it; some minimal charge like that.

THE CHAIRMAN: You would favour that?

MR. O'NEAL: Yes.

THE CHAIRMAN: Thank you very much.

Now, I understand in British Columbia that there are several, and by several I mean there might be many labour-management agreements under which medical service is being provided by management to the employees of the concern.

For instance, we have heard today about the C.P.R. having a programme, the B. C. Electric Company have a programme where the British Columbia Telephone System

have their own programme. What is your view as to what should become of those programmes in this overall compulsory scheme that you see?

MR. O'NEAL: Well, with respect, Mr. Chairman, I am going to have to take a little time to answer this because of the variety of the programmes.

First, you have the facet of it where a company probably likes to provide a programme or some kind of medical care.

Then, you have programmes which are a matter of collective agreements where they sit down and negotiate them.

The drawback with a lot of these is this. When an employee who terminates his employment under one programmes goes to another, maybe there is or is not a programme in the one he goes to. This kind of arrangement is at best a patchwork. We think they should be absorbed into the overall programme.

THE CHAIRMAN: What do you mean by that word absorbed?

MR. O'NEAL: Well, I think this ---

THE CHAIRMAN: What are the mechanics of absorbing it?

MR. O'NEAL: Well, perhaps integrated might be a better word, Mr. Chairman.

THE CHAIRMAN: Or the same thing. I am talking about the mechanics of bringing them together, whichever word you use.

MR. O'NEAL: I think that this is an administrative programme rather than a question of mechanics,

Mr. Chairman. I am quite confident that it could be worked out.

COMMISSIONER McCUTCHEON: When the hospital insurance came into effect in British Columbia, was it not a fact that the arrangements which many firms had for hospitalization for their employees simply went by the boards. There was no integration; they disappeared?

MR. O'NEAL: This facet of it went out and the other one came in. One was replaced by the other.

COMMISSIONER McCUTCHEON: What do you mean by integrate? Does not the one have to disappear?

MR. O'NEAL: I would say it would have to be done in a way that in the period when the one was introduced, the other one was --

THE CHAIRMAN: One died and the other came to life. It would have to coincide?

So there wouldn't be a hiatus?

MR. O'NEAL: That is right.

THE CHAIRMAN: That is what you mean?

MR. O'NEAL: That is right.

COMMISSIONER FIRESTONE: Mr. O'Neal, may I come back first to this addendum you presented to the Commission, this definition. In the fourth paragraph you say those under social assistance for under three months receive no coverage whatsoever. Were you given reasons as to why this is the case?

MR. O'NEAL: No, as I said, this was why we raised this particular point, Mr. Chairman, because since a lot of our members or members of our affiliates have unemployed people on social assistance we have been

very concerned about these matters and have attempted to get to the bottom of it.

THE CHAIRMAN: The doctors will be giving the service when asked?

MR. O'NEAL: I know that some doctors are extremely good in giving services whether they get paid or not.

THE CHAIRMAN: Does the medical profession subsidize the three months?

MR. O'NEAL: I have subsidized it a few times myself where the doctor has sent me a bill when I have sent someone to him. There has been a vagueness about this thing. We thought it was unfortunate to give the idea that this was the way it was when in reality it was very difficult.

COMMISSIONER FIRESTONE: What this Commission is interested to know is why this is the case. If you don't know will you tell us you don't know. If you don't know the reason why people under social assistance in need of medical care are not getting it you don't know.

MR. O'NEAL: It is government policy. We haven't been able to get reasons for that, sir.

COMMISSIONER FIRESTONE: In the following paragraph you say unemployed employables receiving social assistance are excluded by government regulation from receiving medical care.

MR. O'NEAL: That is right.

COMMISSIONER FIRESTONE: Have you been given reasons why people that are qualified and perhaps need medical care more urgently and they can't afford to pay for

MR. O'HARA: I know that some doctors are extremely good in giving services whether they get paid

subscribe the three months?

MR. O'HARA: I have subscribed for a few times usually when the doctor has sent me a bill then I have sent someone to him. There has been a resources who [illegible] Mr. [illegible] and the [illegible] to give the idea what I am in my .e my .t was when in reality it was very difficult.

[illegible]

I interested to know in way than is the case. If you don't know we, you tell us you don't know. If you don't know the reason why people under social assistance in need of medical care are not [illegible] if you don't know.

MR. O'HARA: It is government policy. We [illegible] [illegible] reasons for that, sir.

CHAIRMAN: In the Colorado [illegible] or you may accept, we encourage [illegible]

[illegible]

CHAIRMAN: Have you been given [illegible] are [illegible] and [illegible] need medical care [illegible] and who can't afford to pay for

it as easily as people that are employed, why these people are not receiving medical care?

MR. O'NEAL: No sir, we haven't been given any reasons. We raised it with the Cabinet on two occasions. We got no answer.

COMMISSIONER FIRESTONE: When I said not in receipt of medical care, I am referring to the fact -- they must be looked after, but there is no provision for payment.

MR. O'NEAL: That is the point.

COMMISSIONER FIRESTONE: You haven't received any explanation as to why?

MR. O'NEAL: No.

COMMISSIONER FIRESTONE: May I now turn to your submission where you say Mr. O'Neal, that you, the British Columbia Federation of Labour is in favour of a comprehensive medical care programme which would be financed on the basis of ability to pay; is that correct, sir?

MR. O'NEAL: Well, when you say on the basis of ability to pay, I suggest we have a comprehensive medical care plan and that nobody who cannot pay for the premium should be excluded.

COMMISSIONER FIRESTONE: That is a negative definition. Could we have a positive definition, how should it be paid for?

MR. O'NEAL: We suggest that it should -- this again is a matter that I think should require a lot of proper consultation and co-operation between the federal and provincial governments. First, we take the

position, sir, that Canada needs this kind of planning. Now, how the revenue for it is going to be developed and the relationship between the Province and the Federal Government is a matter, sir, that I don't feel competent to give answers to. We say in the interest of the Canadian people that this kind of plan should be developed for them and some kind of financial arrangement worked out for it.

COMMISSIONER FIRESTONE: We appreciate the point that you put forward. We don't expect -- we are trying to establish certain principles which you may be in favour of. You must have given some thought to how such a scheme could, in practise, be paid for.

MR. O'NEAL: I think, with respect, sir, that I did mention to the Chairman on the basis of taxes. Now, if it is necessary in addition to this to charge a premium, for instance the government might increase income taxes by so much and get X percentage of its requirements from this if it became necessary to establish a premium of X number of dollars. I am just offering this as one of the means which we have now. Undoubtedly there are several others from the point of view of collecting money most efficiently and with less trouble.

COMMISSIONER FIRESTONE: That is very helpful, sir. You are now saying to us that people that can afford to pay the premium should be charged a premium. Those who can pay income tax should be expected to pay income tax if the plan you are proposing requires an increase in income tax you would be in favour of this; is this correct?

[illegible] Chicago needs this kind of [illegible].

[illegible] reason for it is going to be developed and [illegible] based on the revenue and the [illegible] [illegible] is a [illegible], that I don't feel competent to give answers to. We may in the interest [illegible] condition people, that this kind of plan should be developed [illegible] the area kind of financial arrangements [illegible]

COMMISSIONER FINGETON: We appreciate the [illegible] very [illegible] forward. We don't expect -- we are [illegible] conclusive conclusion pitchfork which you may be in favour of. You could have given some thought to how such a [illegible] could, in practice, be paid for.

[illegible] I think, Mr. [illegible], that [illegible] position to the Minister on the basis of [illegible]. [illegible] it is necessary in addition to this to change a [illegible] for [illegible] for government might increase income [illegible] [illegible] [illegible] consequence of the requirement [illegible] it became necessary to establish a premium of [illegible] of dollars. I am just offering this as one [illegible] [illegible] more [illegible]. Undoubtedly there are several [illegible] from the point of view of collecting money [illegible] [illegible] [illegible] [illegible].

COMMISSIONER FINGETON: There is very [illegible] [illegible]. You are now saying to us that [illegible] that [illegible] the premium should be [illegible] a premium, [illegible] [illegible] tax should be opposed to any [illegible]

MR. O'NEAL: That is right, sir. I am not suggesting that income tax alone do it. I said taxes.

COMMISSIONER FIRESTONE: Taxes, of which income tax would be one. Just trying to expand this principle, if such a comprehensive health programme came into being and the government said, Federal, Provincial government were to say, in order to get this we may have to raise sales tax, we may have to raise corporation tax, we may have to raise income tax. This is a supposition. Would you as the leaders of the B. C. Labour movement go to your members and say, fellows, if you want this you have to pay a higher income tax. Would you say that?

MR. O'NEAL: I would say first, sir, with respect, I think you are asking me a question that I would have to look up how the taxes are being allocated. If for instance everybody under $5,000.00 were paying 10% and everybody over $5,000.00 were paying two, if it were a fair tax proposal we would be prepared to recommend it.

COMMISSIONER FIRESTONE: Let us assume it is a fair tax proposal on a progressive basis as we now have in operation, you would be prepared to go to your members and say, fellows, this is the only way of getting the health services and you would be in favour?

MR. O'NEAL: I don't think we would have to go to our members. They would welcome it.

COMMISSIONER FIRESTONE: I take it from what you are saying the union leadership would support such a proposal?

MR. O'NEAL: Yes sir.

COMMISSIONER FIRESTONE: To turn to another

subject, we have, in connection with our hearings across the country been told on some occasions that people felt that drug costs are high. Have you, among your membership run into complaints of this sort?

MR. O'NEAL: Yes sir, we have, and we have received letters from a lot of our members, as a matter of fact, sir, we are doing a complete study into the question of drug prices. We have received a lot of letters, both from individual members and from affiliated unions asking us what are we going to do about it. The only way is to analyze the situation intelligently. We are not going to do anything yet. We are in the process of a research job on that subject now.

COMMISSIONER FIRESTONE: What kind of complaints have you been getting?

MR. O'NEAL: The usual one, sir, is that the drug costs are too high. We have also got complaints where prescriptions, they feel, are much too high, where some of the prescriptions vary in price as much as $2.00 for the same prescription. That is not confined just to the Vancouver area. It comes from different parts of the province.

COMMISSIONER FIRESTONE: You are saying, sir, you are in the process of undertaking a survey. Would it be possible to have the results of the survey made available to the Commission?

MR. O'NEAL: It certainly will, sir.

COMMISSIONER FIRESTONE: When do you think you will complete this?

MR. O'NEAL: I don't think it will be

the country been told on some occasions that people felt that drug costs are high. Have you, among your membership run into complaints of this sort?

MR. O'HALL: Yes sir, we have, and we have received letters from a lot of our members, as a matter of fact, sir, we are doing a complete study into the question of drug prices. We have received a lot of letters from our individual members and from affiliated unions asking us what are we going to do about it. The only way is to analyze the situation intelligently. We are not going to do anything yet. We are in the process of a research job on that subject now.

COMMISSIONER MACDONALD: What kind of complaints have you been getting?

[illegible]

the drug costs are too high. We have also got complaints where prescriptions, they feel, are much too high, where some of the prescriptions vary in price as much as $2.00 for the same prescription. That is not confined just to the Vancouver area. It comes from different parts of the province.

COMMISSIONER FIRESTONE: You are saying, sir, you are in the process of undertaking a survey. Would it be possible to have the results of the survey made available to the Commission?

MR. O'HALL: It certainly will, sir.

COMMISSIONER FIRESTONE: When do you think you will complete that?

completed in the next six weeks because we are going into it very carefully.

COMMISSIONER FIRESTONE: Two or three months?

MR. O'NEAL: I would say it would be two to three months. We will certainly make it available to you.

COMMISSIONER FIRESTONE: We are very grateful to you. Would you say you would be in favour of an independent study to look into the question of whether drug costs are high or not?

MR. O'NEAL: That, sir, we have urged the Provincial Government in our submission to them last year and this year to initiate such a study. We have also asked them to consider the practicability of ~~special~~ drug stores, something the same as we have liquor stores where they could be government-sponsored.

COMMISSIONER FIRESTONE: Would it be possible for you to make available to us a copy of the submission which you have made to the Province on the matter of drugs?

MR. O'NEAL: Yes, sir.

COMMISSIONER FIRESTONE: Would you further say that the recommendations which you made to the Provincial Government, would you be prepared to repeat these as part of the recommendations you also wish to make to this Commission?

MR. O'NEAL: Yes, sir.

COMMISSIONER FIRESTONE: To come to another subject, and this is the last subject, I hope to have your views on, it is the subject of means test. We were advised

MR. O'NEAL: I would say it would be two to three months. We will certainly make it available to

[illegible]

[illegible] you. Would you say you would be in favor of an independent study to look into the question of weather modification [illegible]?

MR. O'NEAL: That, sir, we have urged the Florida Legislature in the submission to them last year and the year to submit such a study. We have also asked them to consider the possibility of sponsoring study concerning the long-range future of weather modification.

CHAIRMAN GRAY: Would it be possible for you to give us a copy of the submission when you have done it, the proposals on the matter of drought?

[illegible]

If you do, [illegible] would be prepared to report back as part of the recommendations you [illegible] make to this Committee?

[illegible]

CHAIRMAN GRAY: Go back to another question. One thing in the last study, or I guess in have gone over it, it is the subject of morgue beds. We were advised

by the B. C. Chapter of the Medical Association that they have made a survey to establish the attitudes of people in British Columbia towards means tests. We were told that on the basis of a sample of less than 400 households covering persons with low incomes that 88% of the people expressed themselves as being willing to put up with the means test as a means of getting medical care easily paid. From your knowledge what are the views of the members of your union, of your various unions, which I understand represent 115,000 members, what are the views of your members on the subject of the means test?

MR. O'NEAL: I would challenge that statement, sir, because in my view, and I think it is shared by my colleagues, and certainly the affiliates, we are opposed to the means test. We feel subjecting anyone to a means test is, in point of fact, subjecting the person to degradation that we don't think anybody wants to undergo. We would go further and say that people who do not require the means test would also take the same view and would be opposed to subjecting their fellow citizens to a means test in order to acquire any of these facilities.

COMMISSIONER FIRESTONE: Would you be able to, because you have 115,000 members, could you say how many would be in favour of a means test and how many wouldn't?

THE CHAIRMAN: It is a poll of one, I take it.

MR. O'NEAL: I would say, sir, that at every single convention we have held where this question came on the floor that it was a unanimous decision that there

should be no means test. Based upon that I think I am fairly safe to say 99% of our people would oppose it.

COMMISSIONER FIRESTONE: When you say your people you are referring to the 115,000 members of the union?

MR. O'NEAL: When I gave you my answer it was a convention representing these people and there would be present 380 to 400 delegates.

COMMISSIONER FIRESTONE: 384?

MR. O'NEAL: 380 to 400.

COMMISSIONER FIRESTONE: Representing how many members?

MR. O'NEAL: Representing the total membership.

COMMISSIONER FIRESTONE: 115,000?

MR. O'NEAL: They always unanimously took the decision there should be no means test.

COMMISSIONER FIRESTONE: Thank you very much, sir.

COMMISSIONER McCUTCHEON: Mr. O'Neal, occasionally some of your members are unemployed?

MR. O'NEAL: Yes sir.

COMMISSIONER McCUTCHEON: Occasionally, I suppose, they run into the situation where their savings are pretty well gone and their unemployment insurance runs out. What do they do under those circumstances?

MR. O'NEAL: If they need medical care?

COMMISSIONER McCUTCHEON: If they need food?

MR. O'NEAL: There is a great variety of different things they do, sir. Some apply for social

[illegible] by no means true. Based upon that a thing I am [illegible]

CHAIRWOMAN FINGSTONE: Will you say your [illegible] you are referring to the 113,000 members of the [illegible].

MR. O'DEAL: When I gave you my answer, it was a question regarding these people and there [illegible].

[illegible]

CHAIRWOMAN FINGSTONE: Regarding [illegible]

MR. O'DEAL: Represent for the total [illegible]

[illegible]

CHAIRWOMAN FINGSTONE: [illegible]

MR. O'DEAL: They claim unemployment from the [illegible] should be no means test.

[illegible]

MR. [illegible]

CHAIRWOMAN FINGSTONE: Mr. O'Deal, [illegible] of your members are unemployed?

MR. O'DEAL: [illegible].

CHAIRWOMAN FINGSTONE: [illegible] suppose they are in the situation where [illegible] are generally [illegible] unemployed [illegible] out. What do they do under [illegible]?

MR. O'DEAL: If they [illegible]

CHAIRWOMAN FINGSTONE: If they [illegible]

MR. O'DEAL: There is a [illegible] different things they [illegible]. Some apply for [illegible]

assistance.

COMMISSIONER McCUTCHEON: What do they do when they apply for social assistance? How is it done?

MR. O'NEAL: Some form has to be filled out stating what assets, if any, you have got, whether you have a car, whether you have got dependants, all of these things are on the form.

COMMISSIONER McCUTCHEON: That is what they call a means test.

MR. O'NEAL: It is an inquisition into how badly you need social assistance.

COMMISSIONER McCUTCHEON: Is it or is it not, in your view, a means test?

MR. O'NEAL: I suppose one could consider it a form of means test, sir.

COMMISSIONER McCUTCHEON: Are you opposed to that?

MR. O'NEAL: Yes.

COMMISSIONER McCUTCHEON: What do you think people should do then who need money to buy children food?

MR. O'NEAL: I would answer you this way, sir, that I think that before anyone is willing to accept the stigma of receiving social assistance that they are extremely hard up and I think that the hardships and the degradations which are imposed on somebody standing in line outside a social assistance office is a sufficient test to establish they are badly in need of help.

COMMISSIONER McCUTCHEON: Your means test would be whether they would stand in line?

MR. O'NEAL: No, I didn't say that, sir.

MR. OWENS: Some form has to be filled out stating what assets, if any, you have got, whether you have a car, whether you have got dependents, all of these things are on the form.

Call a medical [illegible].

MR. OWENS: It is an investigator who has badly got used social assistance.

CHAIRMAN M'CUTCHEON: Is it or is it not, in your view, a proper case?

MR. OWENS: I suppose one could consider it a form of means test, sir.

CHIEF COUNCIL WOODWORTH: Are you opposed to it?

[illegible]

CHAIRMAN M'CUTCHEON: Would you submit people should do [illegible] use need money to buy our food?

MR. OWENS: I would answer you this way, sir, that I think that we are in writing to accept the ruling of provincial social assistance that they are extremely [illegible] and I think that the investigator and the [illegible] which are imposed on somebody starting in the [illegible] social assistance office is a [illegible] test to establish that are really in need or not.

COMMISSIONER McCUTCHEON: I thought that is what you said.

MR. O'NEAL: I don't think I said that. I said that the degradation and the stigma which is attached to standing in line, in seeing your fellow citizens walking by and seeing you, as it were, with your hands out for alms or charity is a sufficient test, in my opinion than the additional requirement of this form.

COMMISSIONER McCUTCHEON: I still think you said what I thought you said. Leave that for a moment. How do you suggest then the community deals with this class of people? Do you suggest I could simply walk in and say I will need $50.00 this week?

MR. O'NEAL: Of course, we get into the realm now of .....

COMMISSIONER McCUTCHEON: You told me you are opposed to the means test. I want to know what you mean, how you want the public money spent.

MR. O'NEAL: On the particular question of social assistance?

COMMISSIONER McCUTCHEON: Let us deal with social assistance where we have the means test. You either approve or you don't approve. If you don't approve tell me what system you would invoke to spend the taxpayers' money.

MR. O'NEAL: The system I would invoke, sir, and I think if one considers the practical aspects it would probably be less expensive if a person walked in and collected social assistance. When you imagine the amount of bureaucracy it would eliminate, the amount of red tape,

the amount of forms. It backs up for miles. I think the percentage of people that might bilk you on this, you would save far more money in eliminating all that red tape and forms, with the few people who might take you for your money.

COMMISSIONER McCUTCHEON: Thank you very much. There is one other point in your final recommendations. You state certain recommendations in your opinion be implemented if Canadians are to enjoy health services comparable to that presently existing in most modern countries. What do you mean by that?

MR. O'NEAL: In my opinion, the service which is attained in Britain is accepted by most people as being pretty up to date, the kind of service a lot of people are working for in the United States.

COMMISSIONER McCUTCHEON: Are you suggesting we in Canada haven't health services comparable to most modern countries?

MR. O'NEAL: No sir, I am not suggesting that.

COMMISSIONER McCUTCHEON: That is fine, thank you.

THE CHAIRMAN: Thank you very much, Mr. O'Neal and gentlemen.

MR. O'NEAL: Thank you very much.

THE CHAIRMAN: We will have a short recess.

---Short recess.

THE CHAIRMAN: We will come now to the submission of the Association for Retarded Children of

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COMMISSIONER MORROW: Are you suggesting we in Canada haven't health services comparable to most modern countries?

Mr. O'HARA: No sir, I am not suggesting that.

The CHAIRMAN: Thank you very much, Mr. O'Hara and co-issues.

The CHAIRMAN: We will have a short recess.

--Short recess.

The CHAIRMAN: We will come now to the submission of the Association for Retarded Children of

British Columbia.

THE SECRETARY: 170, sir.

---EXHIBIT NO. 170: Submission of the Association for Retarded Children of British Columbia.

SUBMISSION OF

THE ASSOCIATION FOR RETARDED CHILDREN OF BRITISH COLUMBIA

APPEARANCES: Mr. Henry H. Goossen, President, Ass'n. for Retarded Children of British Columbia.

Mrs. J. Jeune, Executive Member A.R.C. of B.C.

Mr. Dalton Murphy, Co-ordinator of Services A.R.C. of B.C.

Dr. L. A. Kerwood, (Advisory Capacity only) Medical Superintendent The Woodlands School and member of Advisory Board to A.R.C. of B.C.

MR. GOOSSEN: Your Honour, Chief Justice Emmett Hall, ladies and gentlemen of the Royal Commission. Mr. Chairman, I take great pleasure in introducing the delegation that is here with me. On my immediate right is a most charming lady, Mrs. K. Jeune who is an executive member of the Board of the Retarded Children of British Columbia. Next is Mr. Dalton Murphy, the Co-ordinator of Services for the Association for Retarded Children of British Columbia. Last, but not least in an advisory capacity the Medical Superintendent of Woodlands and also

THE SECRETARY: 770, etc.

Submission of the

Colombia.

SUBMISSION OF

Mr. Henry H. Greenwood,
President, Ass'n. for
British Columbia.

Mrs. J. Doble,
Executive Member
A.R.C. of B.C.

Mr. Dalton Murphy,
Co-ordinator of Services
A.R.C. of B.C.

Dr. L. A. Verwood,
(Advisory Capacity only)
Medical Superintendent
The Woodlands School
and member of Advisory

MR. WOODSMAN: Your Honour, Chief Justice Sherritt Hall, ladies and gentlemen of the Royal Commission. Mr. Chairman, I take great pleasure in introducing the delegation that is here with me. On my immediate right is a most charming lady, Mrs. E. Doble who is an executive member of the Board of the Retarded Children of British Columbia. Next is Mr. Dalton Murphy, the Co-ordinator of Services for the Association for Retarded Children of British Columbia. Last, but not least in an advisory capacity the Medical Superintendent of Woodlands and also

an executive member of the research clinical services and education committee of our Association. Whenever we have any problems we take these problems to this committee and in a number of cases they have helped us tremendously and we appreciate their help, Mr. Chairman.

THE CHAIRMAN: We didn't get the gentleman's name.

MR. GOOSSEN: Dr. Kerwood. I was just advised by my charming colleague I neglected to introduce myself. I am Henry Goossen, Chairman of the B. C. Association for Retarded Children.

THE CHAIRMAN: I didn't get your name.

MR. GOOSSEN: H. H. Goossen.

THE CHAIRMAN: Thank you, Mr. Goossen. Will you proceed.

MR. GOOSSEN: Thank you. Mr. Chairman I am reading. I presume you have the briefs in hand. I am reading from page 1, the summary.

SUMMARY:

In this Brief the health problems posed by mental retardation and the functions of the Association for Retarded Children of British Columbia, are briefly outlined in the introduction. The existing facilities for providing personal health services in this field are then reviewed. Suggestions for the improvement of these services are made. As the Canadian Association for Retarded Children will be submitting a Brief which covers the general problems of mental retardation throughout this country, the present review deals particular with the most pressing needs of the

an executive member of the research clinical services and education committee of our Association. Whenever we have any problems we take these problems to this committee and in a number of cases they have helped us tremendously and we appreciate their help, Mr. Chairman.

THE CHAIRMAN: We didn't get the gentleman's name.

MR. GOODSEN: Dr. Kerwood. I was just advised by my charming colleague I neglected to introduce myself. I am Henry Goosen, Chairman of the B. C. Association for Retarded Children.

THE CHAIRMAN: I didn't get your name.

MR. GOOSEN: H. H. Goosen.

THE CHAIRMAN: Thank you, Mr. Goosen. Will you proceed.

MR. GOOSEN: Thank you, Mr. Chairman I am reading. I presume you have the briefs in hand. I am reading from page 1, the summary.

SUMMARY:

In this brief the health problems posed by mental retardation and the functions of the Association for Retarded Children of British Columbia, are briefly outlined in the introduction. The existing facilities for providing personal health services in this field are then reviewed. Suggestions for the improvement of these services are made. In the Canadian Association for Retarded Children will be submitting a Brief which covers the general problem of mental retardation throughout this country. The present review deals particular with the most pressing needs of th

retarded in this Province.

CONCLUSIONS:

i. Mental retardation is numerically the most important chronic disability of childhood and one of the major problems of public health. The families of affected individuals are also involved in the problem and the social implications are tremendous.

ii. The basic physical and emotional needs of the retarded are no different from those of others, though they may be more difficult to satisfy.

iii. For the prevention of mental retardation in general there is a great need for more medical and basic scientific research. Genetic counselling in affected families is also of great value. The prevention of retardation in individual cases is often impossible in the present state of knowledge, but much can be achieved by a high level of ante-natal and obstetric care and by the early detection and suitable management of diseases and injuries which may lead on to brain damage.

iv. The diagnosis of mental retardation lies largely in the hands of physicians, teachers and psychologists. This is a task of great responsibility, still often poorly or belatedly accomplished.

v. The management has many facets, not only medical treatment where possible, but also parent counselling, social service, special education and vocational habilitation. At present there is considerable shortage of personnel to render these para-medical

Moral rehabilitation is unquestionably the most important chronic disability of childhood and one of the major problems of public health. The training of [illegible] are also involved in the

i. The [illegible] of the [illegible]

ii. [illegible]

iii. [illegible]

iv. [illegible]

v. [illegible]

services. Further, there is a shortage of residential facilities, i.e. not only insufficient accommodation in training schools but also a lack of short-stay hostels, halfway houses and day care centres in this Province. The establishment of sheltered and training workshops for the retarded is still in its infancy.

Now let us consider the recommendations.

i. Government at its various levels should increase its contributions to research in the field of mental retardation. Prevention should also be promoted by emphasis on genetic counselling and by financial support for the training and employment of suitable professional staff.

ii. In the instruction of medical students, more time should be devoted to teaching concerning mental retardation. During post-graduate training, hospital residents should be given an opportunity to work in training schools for the retarded during a period of not less than 3 months; this applies particularly to residents in paediatrics and psychiatry. The problems of mental retardation also deserve more emphasis in post-graduate "refresher" courses, especially for general practitioners.

iii. Diagnostic clinics for the retarded should be established at children's hospitals, training schools and other suitable locations. Travelling teams, attached to hospitals, training schools or day centres, should be established not only to

services. Further, there is a shortage of residential facilities, i.e. not only insufficient accommodation in training schools but also a lack of short-stay hostels, halfway houses and day care centres, and therefore the rehabilitation and training workshops for the retarded is still in the infancy.

Now let us consider the recommendations.

i. Advancement of the various levels should increase the contributions to research in the field of mental retardation. Prevention should also be promoted by emphasis on genetic counselling and b. financial support for the training and supervision of suitable professional staff.

ii. In the instruction of medical students, more time should be devoted to learning concerning mental retardation. During post-graduate training, medical and teaching staff should be given an opportunity to work in training schools for the retarded during a period of not less than 3 months; this would be preliminary to research in paediatrics and psychiatry. The problems of mental retardation

[illegible] funding for the retarded should be [illegible] in California hospitals, including schools and other suitable institutions. Generally speaking, attached to hospitals, residential or day centres, should be established not only to

assist in the diagnosis of mental retardation in rural areas but also to help with the subsequent management problems.

iv. Facilities for the retarded should be provided in small regional units close to the individuals' homes and community. Such facilities comprise residential accommodation, short-stay hostels, and halfway homes, as well as training schools, sheltered work shops, occupation centres and day care centres. These centres can also serve as focal points for the home care programme with its requirements for social service, parent counselling, special education, speech therapy, and other para-medical facilities.

Then I would like to insert another recommendation or request that a pilot study should be made as to the incidence and the extent of the problem. I think before we can consider the cost of what is going to be done for the mentally retarded children I think it is important we know what is the incidence. We have been given all kinds of facts and figures. I am quoting, Mr. Chairman, from a survey conducted by the National Survey of Mental Retardation conducted by the Canadian Press and the National News Wire Service. There are 30 retarded out of every 5,000, or otherwise every 25 minutes a retarded child is born which is a tremendous figure when you compare it with some of the other maladies that strike children. I am quoting: Rheumatic heart disease, six are affected out of every thousand; cerebral palsy, three to five out of every thousand; polio with permanent crippling, 3%;

[illegible]

rural areas but also to help with the subsequent

[illegible]

facilities for the retarded should be provided in small regional units close to the individuals' homes and community.

[illegible]

residential accommodation, short-stay hostels, and day hospitals, as well as training schools, sheltered work shops, occupation centres and day care centres. These centres can also serve as local points for the home care programme with its regular visits by social service, parent counselling, special education, speech therapy, and other para-medical services.

Then I would like to insert another recommendation or request that a pilot study should be made to [illegible] the extent of the problem. I think it is [illegible] to see [illegible] the cost of [illegible] so as [illegible] the mentally retarded children I think it is important we know what is the incidence. We have been given all kinds of facts and figures. I am grateful, Mr. Chairman, from a survey conducted by the National Society of Mental Retardation, conducted by the Canadian Press and the National News Wire Service. There are 30 retarded out of every 3,000, or otherwise every 25 minutes a retarded

[illegible]

an country: Rheumatic heart disease, air are affected

[illegible]

of every thousand; polio with permanent crippling, 3%;

1 blindness, two are affected out of every thousand.
2 Therefore it is a tremendous problem and in order to know
3 exactly what we are talking about, both in this province
4 and in the other provinces, this problem is not being
5 dealt with in the overall picture, what we are talking
6 about -- I simply suggest that a pilot study be conducted
7 to find out exactly the extent of the problem and the
8 incidence of it. As you know, Mr. Chairman, a few minutes
9 ago I stated every 25 minutes a child was born. The
10 minute a child is born he starts a life-long process,
11 life-long problem, a problem, Mr. Chairman and members of
12 the panel that we must face and that we must cope with and
13 it is going to cost us money. I think the intelligent
14 thing to do is to invest that money in such a manner, in
15 such a fashion that we gain the most out of it and spend
16 the money in such a fashion, spend it wisely. I am sure,
17 ladies and gentlemen, we all recognize that the home has
18 done a tremendous job. Mental retardation has been rising,
19 and it has been the home that has been coping with this
20 problem valiantly from year to year, from age to age until
21 to date, we find that as intelligent human beings we are
22 no longer pushing aside this problem or sweeping this
23 problem under the carpet. We are bringing these children
24 up into the limelight. The retarded child can be helped
25 and if the dollar is wisely spent surely it is going to
26 bring results, not only in relief to the home, to the mother,
27 to the father, to the other members of the family, but to
28 the child itself. That brings me to the last point I would
29 like to stress here, Mr. Chairman. I would like to call
30 upon some of the other members of our delegation here. I

[illegible]

[illegible]

and in the other provinces, this problem is not being dealt with in the overall picture, what we are talking about -- I simply suggest that a pilot study be conducted to find out exactly the extent of the problem and the incidence of it. As you know, Mr. Chairman, a few minutes ago I stated over 25 minutes a child was born. The minute a child is born he starts a life-long process. Life-long problem, a problem, Mr. Chairman and members of the panel that we must face and that we must come with and it is going to cost us money. I think the intelligent thing to do is to invest that money in such a manner, in such a fashion that we gain the most out of it and spend the money in such a fashion, spend it wisely. I am sure, ladies and gentlemen, we all recognize that the home has done a tremendous job. Mental retardation has been neglected and it has been the home that has been coping with this problem relatively from year to year. From age to age until so late, we find that we intelligent human beings are no longer prepared to solve this problem or accepting this problem under the carpet. We are bringing these children up into the institutions. The retarded child can be helped [illegible] to the normal, to the other members of the family, but to the child itself. That brings me to the last point I would like to express here, Mr. Chairman. I would like to call upon some of the other members of our delegation here. I

think that we are all prepared to give the best possible health care to these mentally retarded children. How can we do it, we have set forth in this brief. Every association for retarded children right across this great Canada of ours is doing likewise and you will have the master brief presented by the Canadian Association for Retarded Children. I am sure you will agree with me that each child should be able to develop its potentialities to the best of that child's ability. Will you give the child a chance, Mr. Chairman and members of the panel? Let us do all we can and I am sure we can do tremendous things. I thank you.

THE CHAIRMAN: Thank you very much, Mr. Goossen. Were you going to call upon some of your associates to make some further statements?

MR. GOOSSEN: As you wish, Mr. Chairman.

THE CHAIRMAN: It is entirely within your hands the manner in which you make your presentation.

MR. GOOSSEN: In that case, Mr. Chairman, I would like to call Mrs. K. Jeune and then call upon Mr. Dalton Murphy to say a few words.

MRS. JEUNE: Thank you, Mr. Chairman.

I would like to elaborate on point three of the recommendations, and that is the need for diagnostic clinics. As you are probably well aware, British Columbia is a large province and geographically there is a great problem that it is not a flat province. We have a number of mountain ranges, river streams, and small communities scattered hither and yon over the face of the province.

It is extremely difficult for a diagnostic team to cover any more than a small area, and it means that

[illegible] Hansard Debates, 1962 [illegible]

handicap owing to these morbidly retarded children. How can we do it, we have set forth in this brief. Every association for retarded children right across this great Canada of ours is doing likewise and you will have the master brief presented by the Canadian Association for Retarded Children. I am sure you will agree with me that each child should be able to develop its potentialities to the best of that child's ability. Will you give the child a chance Mr. Chairman and members of the House? Let us do it! We can and I am sure we can do tomorrow morrow. I thank you.

THE CHAIRMAN: Thank you very much, Mr. Goodson. Were you going to call upon some of your associates

MR. GOODSON: As you wish, Mr. Chairman.

THE CHAIRMAN: It is entirely within your hands the manner in which you make your presentation.

[illegible]

Gordon Hardy to say a few words.

MR. HARDY: Thank you, Mr. Chairman.

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It is extremely difficult for a diagnostic team to cover any more than a small area, and it means that

in large areas of the province there are children whose abilities or whose disabilities have not been adequately diagnosed or assessed.

There are many children in chapter schools who have never had their disabilities adequately diagnosed nor assessed.

Since a valid programme in a chapter is only as valid as its set-up for the children who are using it, if the children's needs have not been adequately assessed, it is very difficult to produce a programme that will be valid for them, and I would suggest that one of our greatest needs in British Columbia is more diagnostic teams; more availability of the type of diagnosis and assessment that comes through our recommendations, were they to be implemented.

THE CHAIRMAN: On page 11, you refer to this matter of a travelling diagnostic team. That is what you have in mind; that is what you are speaking of now?

MRS. JEUNE: Yes, this is the type of thing.

THE CHAIRMAN: How many such teams do you suggest you would need in the Province of British Columbia to cover this territory?

MR. GOOSSEN: I would suggest two, Mr. Chairman. I believe one team was prepared to go out, but there again we ran into the problem of personnel and this team did not actually get airborne. We feel that one team is not quite sufficient; two teams would do the job much better.

THE CHAIRMAN: Cost about $50,000.00 a year

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THE CHAIRMAN: Cost about $50,000.00 a year

each?

MR. GOOSSEN: It could very well amount to that, yes.

Mr. Murphy, maybe you would like to say a few words.

MR. MURPHY: Yes, I would like to suggest, Mr. Chairman, that in the matter of education of these children than an additional assistance to the community should be made available through, perhaps, additional financial assistance from the senior government. The requirements of the retarded child in terms of teaching and training are considerably greater, as you are well aware, than those of a normal child. The teacher-pupil ratio is considerably smaller, and as a consequence to handle the education on a group of retarded, moderately retarded children in a community poses an additional strain on that community, and it would seem that consideration of additional financial support in this area might well be given by our senior government.

There is one other thing I would like to amplify in connection with the geographical problem that we have in this province. Our brief recognizes, of course, that the retarded child and his family are probably the greatest users of all community services because the problems involved in retardation are multiple in most cases.

To provide these services requires additional personnel which would, of course, have to be made available through the regular channels, and under the direction of existing welfare -- that, in social departments and medical departments of the various governments -- but the establish-

GOODSMAN: It could very well amount to that, yes.

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To provide these services requires additional personnel which would, of course, have to be made available through the regular channels, and under the direction of existing welfare -- that, in social departments and welfare departments of the various governments -- but the establish-

ment of small regional facilities which can serve as a centre of counselling, of continuing assistance to the parent in terms of the management of the children -- because, as we have suggested, sir, the degree to which the home environment carries on the suggested treatment or guidance of these children is pretty well the measure of the advancement the child can make. So that, if a continuing source or resource is made available to parents then the problem of the management of these children can be better governed.

They would probably be best expedited through the manner of these regional facilities by competent counsellors and medical advisors.

THE CHAIRMAN: Do you wish to add anything, Dr. Kerwood?

DR. KERWOOD: No, sir, I will not speak directly to this group, if I may be excused.

MR. GOOSSEN: Mr. Chairman, if I could then possibly ask you to consider, also, in the recommendation number 4, we would like to underscore that in particular because of the very fact that we are a volunteer agency, and we go out; we raise money, and we try to do all we can. With provincial assistance and local assistance, we are able to instigate certain programmes. We have to go just a little more beyond that. For instance, the facilities you will find in the small community are, possibly, the halfway homes, the day care centres ---

THE CHAIRMAN: What do you mean by "Halfway homes"?

MR. GOOSSEN: A halfway home, I would say,

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THE CHAIRMAN: What do you mean by "halfway homes"?

is a home where these youngsters that come out of institutions, that can come out, can assemble in these homes and then possibly take on a position, and then come back to this position. It is more or less a residence for these youngsters or retardeds that will afford them a little bit of a sort of sheltered residence.

Speaking to hostels, I can tell you a little more about hostels because atChilliwack we have just completed a 10-bed hostel. That is to take the pressure that becomes apparent in the home where there is a retarded child. That mother must get some relief, and if the environment in their home is such that conditions break down, well, that child can be moved into the short-stay home, and then when the environment at home is repaired the child can go back and can be cared for again.

Now, we have the facilities in this province where the retardeds live in, for instance, the institutions, the short-stay home, the halfway home, and then we also have certain associations which have what we call a sheltered workshop.

THE CHAIRMAN: You appear to have made as much, if not more progress in this line than, perhaps, anywhere in Canada?

MR. GOOSSEN: That could possibly be, Mr. Chairman.

I am a charter member of the B.C. Association. We started in 1955. We are only young, but we are a dedicated group that have gone all-out, and we have made tremendous sacrifices individually and collectively. And whereas we have made in-roads, particularly in the case of

is a home where those youngsters that come out of institutions, that can come out, can assemble in these homes and then possibly take on a position, and then come back.

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the short-stay home, we have government participation; the provincial government.

THE CHAIRMAN: That is what we heard in Victoria the other day.

MR. GOOSSEN: Yes, sir.

THE CHAIRMAN: That a direction by the province, particularly, in the educational field. I mean, in support of the school. That is quite pronounced. It may not be sufficient for the need, but ---

MR. GOOSSEN: We have in the province 51 chapters and of these chapters, there are approximately eight which have been taken over by the school board. That is education.

We have presented briefs to the Provincial Government from time to time, and we have had a wonderful response in that we have been granted grants in aid in respect to education, and therefore we have been able to instigate a programme for these kiddies.

In the case of health, for instance, in the form of the short-stay home, the provincial government, when we presented the brief on behalf of the Chilliwack Chapter, the Province undertook to give us a grant of one-third of the cost. Therefore, that is a step in the right direction.

Mr. Chairman, it also points to decentralization, whereby these kiddies can be looked after in these homes. And, therefore, the pressure of the long waiting list that exists in the case of institutions, why, there is a measure of relief. And if more of these short-stay homes can be built in the various smaller communities, where the community

the absentee-ly home, we have given

THE CHAIRMAN: That is what we heard in

MR. ROSSOW: Yes, sir.

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MR. ROSSOW: We have in the province 3 chapters and of these chapters, there are approximately eight which have been taken over by the school boards. That is correct.

We have presented briefs to the Provincial Government from time to time, and we have had a tendency to indicate in that we have been treated grants in aid in respect to education, and therefore we have been able to distribute a pro rata for these kiddies.

In the case of health, for instance, in the form of the school-room home, the provincial government, when we presented the brief on behalf of the Children's Aid Society, the province undertook to give us a grant of one third of the cost. Therefore, that is a step in the right direction.

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comes in and helps along and shares the cost on a voluntary basis, it certainly is going to be reflected in that -- I am not saying that your costs of the operation to the institution is going to diminish, but the pressure is certainly going to be off. The value to the retarded child, here, that child from time to time can go home. From time to time, the parents can come and visit the child. Those are all values that we must not underestimate.

THE CHAIRMAN: Mr. Goossen, we are talking -- I mean, it is being talked that there should be an overall national health programme which would, of course, include the retarded child, as well as everyone else.

If such a programme should come about, what do you see as the function of your association in such a situation? Even if the financial burden was lifted from the problem, is there still a need for the continuance of your organization?

MR. GOOSSEN: Yes, definitely.

THE CHAIRMAN: What will be the part of the voluntary organization in the event of an overall health programme?

MR. GOOSSEN: Well, Mr. Chairman, I feel that these volunteers will still come forward. If there is money available, we will still come forward and instigate a programme, and possibly enhance the programme of our creation, training playgrounds, facilities --

THE CHAIRMAN: The mere providing of money will not take care of the whole situation?

MR. GOOSSEN: No, no.

THE CHAIRMAN: Have you a question, Miss

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MR. COSGROVE: Yes, definitely.

THE CHAIRMAN: It will be one part of the voluntary organization in the event of an overall health programme.

MR. COSGROVE: Well, Mr. Chairman, I think that from volunteers will still come forward. If there is money available, it will still come forward and institute a programme, and possibly enhance the programme of our organization, training manpower, facilities --

THE CHAIRMAN: Do more regarding of money will not take care of the whole situation?

THE CHAIRMAN: Have you a question, Miss

Girard?

COMMISSIONER GIRARD: Yes, Mr. Chairman. I have a question on the recommendation number 1, where you say:

"Government at its various levels should "increase its contributions to research in "the field of mental retardation. Preven- "tion should also be promoted by emphasis "on genetic counselling and by financial "support".

What kind of financial support do you mean here? Do you mean bursaries?

MR. GOOSSEN: I had bursaries in mind, and also probably grants in aid.

COMMISSIONER GIRARD: When you have bursaries in mind, what types of bursaries -- how much should these bursaries be?

MR. GOOSSEN: Well, for instance, to answer that in a different manner, we have a bursary that will be functioning here possibly by late Fall whereby financial assistance is going to be given to one or two people that are taking a special interest in retardation, as post-graduate work.

COMMISSIONER GIRARD: Should this money come to your association and then you would be giving the bursary, or should you have government bursaries?

MR. GOOSSEN: They can very well be govern- ment bursaries, but I am sure the Association for Retarded Children of British Columbia would be very pleased to receive them and appoint a committee to look after it.

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MR. GOODSON: They can very well be govern- ment bursaries, but I am sure the Association for Retarded Children of British Columbia would be very pleased to receive them and appoint a committee to look after it.

COMMISSIONER GIRARD: Those that you have?

MR. GOOSSEN: Or it could be both.

COMMISSIONER GIRARD: Those that you have mentioned will be your own organization bursaries? The money will come from your association?

MR. GOOSSEN: Well, in part the money could be coming from the Association, because after all we do go out and raise funds.

COMMISSIONER GIRARD: The ones you are talking about -- you do have some bursaries now?

MR. GOOSSEN: We have one bursary functioning from a prominent anonymous donar who gave a certain sum of money, and that is being matched. But, in dealing with these bursaries, we must be guided by professional guidance.

COMMISSIONER GIRARD: When you speak about day care centres in homes or in foster homes, do you have day care in foster homes? Is that a prevalent method? You say here "day care" and, then, you say in brackets "in homes and in foster homes".

MR. GOOSSEN: May I ask Mr. Murphy to answer that question?

MR. MURPHY: Mr. Chairman, the question of day care has been given considerable attention here, and the three or four suggestions have been outlined as to how this may be done.

At present, the only facility for day care other than institutional is in one of our chapters where the children are brought to a central location, which happens to be a room in one of the schools, and they are looked after and given what training and care they can

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absorb and require under the care of a competent nurse with psychiatric training. The alternative has been suggested that it is not necessary, perhaps, to create another facility if competent foster home care can be found.

COMMISSIONER GIRARD: For day care?

MR. MURPHY: Just for day care, yes, rather than for a longer term.

MRS. JEUNE: May I speak to that, please?

COMMISSIONER GIRARD: Yes.

MRS. JEUNE: This, also, involved children who were so retarded that they could not take part in a chapter school programme or in a school class under the School Board. This is getting further down in the I.Q. level, where different things are necessary.

COMMISSIONER GIRARD: Thank you very much.

THE CHAIRMAN: Thank you very much, Mr. Goossen and Mrs. Jeune, Mr. Murphy and Dr. Kerwood. The work you are involved in is one that has a tremendous emotional appeal to us all, and you may be sure your presentation will have our earnest consideration.

MR. GOOSSEN: Thank you very much, Mr. Chairman.

THE CHAIRMAN: The Metropolitan Hospital Planning Council.

---EXHIBIT NO. 171: Submission of the Metropolitan Hospital Planning Council.

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MR. GOOSEN: Thank you very much, Mr. Chairman.

THE CHAIRMAN: The Metropolitan Hospital Planning Council.

---EXHIBIT No. 1(i): Submission of the Metropolitan Hospital

SUBMISSION OF

METROPOLITAN HOSPITAL PLANNING COUNCIL

APPEARANCES: Mr. D. A. Thompson
Mr. Orsen Vanfield
Dr. James Mather
Dr. C.J.G. Mackenzie
Mr. G. Ruddick

MR. THOMPSON: I am here, Mr. Chairman, in my capacity as Chairman of the Metropolitan Hospital Planning Council. I have with me on my far left, Mr. George Ruddick, who is assistant superintendent at the Vancouver General Hospital, Dr. Courtney Mackenzie, who is certified in public health. Next, Dr. James Mather, who is the head of the department of preventive medicine at the University of British Columbia Faculty of Medicine, and beside him is the vice-chairman of the council, Mr. W. Orsen Vanfield, who is past chairman of the Board of Trustees of the Vancouver General Hospital and an alderman of the City of Vancouver.

I do not propose to make a verbal delivery of our brief which was submitted some time ago, and we hope that it has been read. If we were to take the time to read and analyze the report and the appended exhibits, we would be here long after health care was of any personal interest. I would therefore submit that all we wish to do is give the Commissioners some idea of what we are doing.

We think that this Council is in a forefront of hospital development, certainly in North America. I

Mr. D. A. Thompson

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MR. THOMPSON: I am here, Mr. Chairman, in my capacity as Chairman of the Metropolitan Hospital Planning Council. I have with me on my far left, Mr. George Ruddick, who is assistant superintendent at the [illegible], who is the head of the department of preventive medicine at the University of British Columbia Faculty of Medicine, and beside him is the vice-chairman of the council, Mr. W. Owen Vanfield, who is past chairman of the Board of Trustees of the Vancouver General Hospital and an alderman of the City of Vancouver.

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1 think there are possibly one or two other places on the
2 continent where this has gone forward as rapidly as here,
3 and I think that is in Kansas City and in Cleveland, and
4 a great deal of interest has been shown in what we are
5 doing here now by the City of Toronto.
6 The foundation of this council was quite
7 unique in that it was a voluntary assembly. During the
8 1949 convention of the British Columbia Hospitals
9 Association, at which time we called together for a luncheon
10 meeting all the chairmen of the hospital boards in the
11 area, the various mayors, reeves and political representa-
12 tives of the area, representatives of the medical pro-
13 fession, of the University of British Columbia, and other
14 interested bodies. Out of this arose a very informal
15 voluntary group which has come to be known as the Metro-
16 politan Hospital Planning Council.
17 When this happened, the Honourable Eric
18 Martin asked us to undertake a certain survey work on
19 behalf of the Hospital Insurance Service and his department
20 of government. So, therefore, it bears, shall we say, a
21 semi or a quasi official stand in that all hospital
22 development in this area, which stretches now from West
23 Vancouver to the American border, and as far east, I
24 would think, the Pitt River, all hospital development in
25 that area is now referred, firstly, to this council and
26 recommendations are made after surveys and upon the basis
27 of these recommendations it is hoped that the Department
28 of Government concerned will base its decisions.
29 To date, we have had federal health grants
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To date, we have had federal health grants supporting this work, and we have hired professional

surveyors to conduct the work. We have completed a study into the referral patterns which take place in the area showing where patients go and why they go there. We have conducted a survey of emergency departments in the area to see what sort of facilities are needed, and what aid we have, and to what extent are they used. We have conducted a pilot project into what has become known as bed utilization, in which we attempt to ascertain whether or not the beds that we have are properly used or whether they are not.

We are, also, at present, conducting a survey into the field of pediatrics and something which is called a study of Demography, which I have never yet been able to get into my head, but which Dr. Mather knows all about.

THE CHAIRMAN: I understood that copies of these surveys that you mention have been forwarded to Ottawa?

MR. THOMPSON: That is right, Mr. Chairman.

THE CHAIRMAN: That is the data relating to volume of referrals and types of patients; and a study of emergency departments in hospitals in the metropolitan area of the lower mainland of British Columbia, and also hospital utilization in the metropolitan area of the lower mainland, a study of the referral patterns in operation in the Province of British Columbia?

MR. THOMPSON: Yes, sir.

THE CHAIRMAN: This will be known as Exhibit 171A, Exhibit 171B, and Exhibit 171C in the order I mentioned.

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---EXHIBIT NO.171A: Data referring to volume referrals and types of patients.

---EXHIBIT NO. 171B: A study of emergency departments in hospitals in the metropolitan area of the lower mainland of British Columbia 1960-1961.

---EXHIBIT NO. 171C: Hospital utilization in the metropolitan area of the lower mainland, a study of the referral patterns in operation in the Province of British Columbia.

THE CHAIRMAN: These are the studies that have been made?

MR. THOMPSON: Yes, Mr. Chairman, and for the purpose of our discussion, perhaps it would be simple to say that generally speaking the work falls into two separate categories. The one is technical and professional and has to do with medical care, hospital care and the why and the how of it. The other is financial. The Federal Government has provided us with upwards of $55,000 to date, which which we have conducted these technical services.

However, the field of financial analyses is one in which the federal health grants are not available. We are at present attempting to get local governments and the provincial government into agreement as to their acceptance of a proportion of the required cost of conducting these financial surveys. The financial surveys themselves will investigate to what proportion municipalities and cities in the area should contribute towards the capital construction of hospital facilities.

EXHIBIT NO. 17IA:	Data referring to volume referrals and types of patients.
---EXHIBIT NO. 17IB:	A study of emergency department in hospitals in the metropolitan area of the lower mainland of British Columbia 1960-1961.
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Apart from that portion which is received from the federal government and that portion with is received from the provincial government there is --

THE CHAIRMAN: Whether those hospitals be municipally based or voluntary hospitals?

MR. THOMPSON: Whether they be municipally based, or voluntary, yes, sir. There is a portion which is, shall we say, the community share.

Now, some sort of formula will have to be worked out as to how a metropolitan area should bear this expense, and in what proportion. We have, at the present time, a very unsatisfactory situation in which just roughly speaking, I would think, between West Vancouver and North Vancouver, the City of Vancouver, Burnaby and New Westminster, have spent something in the neighbourhood of $15 million in the last ten years in those hospitals which are thought of as municipal hospitals: Shall we say, Lionsgate Hospital, the Vancouver General Hospital, the Burnaby Hospital, and the hospital in New Westminster. The other hospitals in the area have no official support, and this now becomes a problem in that cities are recognizing their responsiblity to all hospitals, and we are going to attempt to arrive at a formula under which all institutions will receive some sort of proportional support in their capital programmes. I think that is a general statement of the financial side of the survey which has taken place thus far. The technical and professional side, I would not feel competent to comment upon. I would simply refer any questions which the Commissioners may have to my professional colleagues.

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THE CHAIRMAN: Thank you very much, Mr. Thompson. Did I understand there were some surveys additional to these three that might be available?

MR. THOMPSON: Yes, sir. There will be two surveys, I would think, ready within a month.

THE CHAIRMAN: And if we might be provided with them when they are available, it would be of assistance to us.

If any of these four gentlemen have any statement or observation to make, we would be glad to hear from them.

DR. MATHER: I hesitate to add this, in view of the --

THE CHAIRMAN: Go ahead, Dr. Mather.

DR. MATHER: I had understood that the legal profession are more learned than the medical. It is obvious Mr. Thompson is begging the question. The derivation of the word mentioned by him is quite a classical one, Mr. Chairman, and demoths the people.

Perhaps I might amplify it a little bit on the points Mr. Thompson referred to as regards the project. If I might read:

/hm

"A review of the demography of hospital utilization comprising a correlation of the 1961 hospital admission-discharge data to the 1961 census information in order to determine patterns of medical care and use of hospital facilities as related to population, physician and hospital location. Emphasis will be placed upon demographic indices within the following two areas: (1) availability of health services, and (2) utilization of health services.

This is an extension of the service provided through National Health Grant #609-9-109 during the fiscal year 1961-62.

Using standard indices of hospital utilization, data will become available which will be of value in interprovincial and international comparisons."

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Using standard indices of hospital utilization, data will become available which will be of value in interprovincial and international comparisons."

We have found our surveys give us fundamental base line data that didn't exist anywhere else. When we put the 1961 census into correlation that will allow us to compare figures throughout the country.

Speaking for the University, we have been, I think, uniquely fortunate in this movement that has taken place. This is my department. We have research activities. We have been more than willing to do it. We hadn't entered on the other aspects Mr. Thompson referred to. We have now completed three studies. There will be two others completed. We feel this is adding to the general knowledge that doesn't exist anywhere else in Canada and few other places in the world. I think this work should go on continually. We have financed this from the national health grants, which have certain restrictions. We are going to need a lot more money in future if this work is to be continued. I feel this fundamental work should go on because the hospital utilization has been so vast in this country any money expended wisely in this field is going to be returned many times.

One figure that Madam Commissioner yesterday referred to was the figure used for nursing care of three hours per patient per day. I think she very graphically pointed out how ancient that figure is. The figure we used, 5.7 beds per thousand population, I suggest that figure is just about as useless. I don't think anyone can back up that figure at all. The only way we can, if we get below 5.7 the newspapers come out in headlines. I am not sure that is a realistic figure at all. I think that these studies and similar ones should be continued,

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should be done elsewhere. I think we spend so much money on hospitalization in Canada and we are going to spend so much in the future it behooves us to have some baseline data.

THE CHAIRMAN: Thank you very much.

MR. THOMPSON: I should mention at page 5 of the brief as submitted, it has been amended. The amendment is not significant. It adds a few words, one sentence. I thought I should bring it to your attention. The recommendations are contained on page 4 and 5. I don't think I will take the time to read them to you. Basically they suggest that this sort of organization shouldn't take place in Vancouver or the lower mainland of British Columbia, but take place throughout the province and take place throughout the country, both in the metropolitan areas, in the cities and rural, and this organization should have government support.

THE CHAIRMAN: Well gentlemen as you will appreciate the information that you have given us is information which requires study and consideration and the studies made will go to our research people in Ottawa and we would be very happy to have any further information as it becomes available. Dr. Mather, you refer to some restrictions in the use of the grants. Is there any recommendation that you wish to make there that might free them?

DR. MATHER: I wouldn't think at this moment I would be competent to make a detailed recommendation.

THE CHAIRMAN: As you run into obstacles and

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DR. MATHER: I am of Scottsh ancestry. I can't cover my office expenses.

THE CHAIRMAN: We are very grateful to you, gentlemen, for this presentation and for the additional help that we have had from the surveys and will have from them.

Dr. Black, you wished to read a document in. You are filing a submission.

THE SECRETARY: 172, sir.

---EXHIBIT NO. 172: Submission of the North Shore Union Board of Health.

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THE SECRETARY: Yes, sir.

---EXHIBIT NO. 175: Submission of the North Shore Union Board of Health.

SUBMISSION OF

THE NORTH SHORE UNION BOARD OF HEALTH

APPEARANCES: Dr. D. Black

THE CHAIRMAN: Dr. Black?

DR. BLACK: Mr. Chairman, this is a very brief presentation. The North Shore Union Board of Health, which administrates general public health services to the North Shore of Burrard Inlet feels there are grave inequities in the distribution of the costs between the provincial and federal governments and the local government, that a very heavy load is placed upon the municipalities and the school boards that form the health unit. The appendix shows that 81.7% of our 1961 budget was raised from local sources. We feel this is probably not only a local problem but there is a tendency in urban and suburban areas to levy an undue proportion of the cost of local public health services on direct tax on the citizens of those areas.

This is an extremely short brief and touches on just this one subject and it doesn't need a great deal of elaboration.

THE CHAIRMAN: We haven't it before us. You were brought forward from tomorrow morning. We will deal with it in due course. Thank you very much, sir.

We will now have the G.F. Strong Rehabilitation Centre.

THE SECRETARY: Number 173.

---EXHIBIT NO. 173: Submission of the G. F. Strong Rehabilitation Centre.

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THE SECRETARY: Number 173.

---EXHIBIT NO. 173: Presentation of the G. F. Strong Rehabilitation Centre.

SUBMISSION OF

G. F. STRONG REHABILITATION CENTRE

APPEARANCES: Dr. A. C. Pinkerton
Mr. E. J. Desjardins
Dr. J. R. Naden

DR. NADEN: Mr. Chairman, members of the Commission, on behalf of the G. F. Strong Rehabilitation Centre I would like to introduce Dr. A. C. Pinkerton, Medical Director of the G. F. Strong Centre and a specialist in physical medicine and research with qualifications in Great Britain and Canada, who has been on the staff of the G. F. Strong Centre full time since 1953 and medical director since 1954. On my immediate right is Mr. E. J. Desjardins, manager of the G. F. Strong Rehabilitation Centre, and has been since its inception in 1949. I am Dr. J. R. Naden, Vice-President of the G. F. Strong Centre and Chairman of the Management Committee. I appear on behalf of Mr. Gordon T. Southam, who is absent and expresses his regret at his inability to be present because he is out of town. I would like to read only the letter of transmittal which was sent with our brief, and then I will ask Mr. Desjardins to present the brief in part.

Dear Sirs:

The subject matter of this report is related primarily to the rehabilitation of the physically disabled and to the role of the comprehensive rehabilitation centre in the structure of provincial and local community health services, particularly as it involves severely disabled children and adults.

Dr. A. G. Pinkerton

Dr. J. E. Nader

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The subject matter of this report is related primarily to the rehabilitation of the physically disabled and to the role of the comprehensive rehabilitation centre in the structure of provincial and local community health services, particularly as it involves severely disabled children and adults.

We have endeavoured to present those matters which, in our opinion, would be of special interest and concern to the Government of Canada and which are based on an underlying concern for comprehensive rehabilitation services in British Columbia and the particular problems experienced by the G. F. Strong Rehabilitation Centre.

While the complexities of many of the subjects dealt with in this report make possible the formulating of only broad recommendations in a number of instances, we have nevertheless delineated the needs, with the recommendation that they receive detailed study by a committee or committees more extensively qualified for this responsibility. We will be pleased to make available the services of senior, experienced personnel from our Centre to assist in these studies if requested.

Yours truly,

Gordon T. Southam, President.

Mr. Chairman, with your permission I would like to ask Mr. Desjardins to present the report.

THE CHAIRMAN: Mr. Desjardins.

MR. DESJARDINS: Mr. Chairman and members of the Commission, in view of the strenuous day you have obviously had maybe it is appropriate to conclude with a brief on rehabilitation. My plan in presenting this brief was to deal with the summary and conclusions, to precede that with some introductory remarks and offer some elaboration on five of the points in the summary of recommendations and needs.

I have attempted to prepare this brief in accordance with your instructions and particular note was

MR. BLACK: That is right.

THE CHAIRMAN: The plan was put into operation, and they said, "That is where you are going to get your hospitalization", without any responsibility to the person who put it up.

MR. BLACK: The Vancouver General is the largest hospital in the metropolitan area. It is community-owned hospital for the City of Vancouver and the citizens of the City of Vancouver. In St. Paul's, a large institution within the orbit of the City of Vancouver, it is owned by that particular religious order, and they have now been relieved of a great deal of responsibility because today through the pooling of resources, their pick-up and their operation is taken care of.

Without being presumptious, I would say that the people of the Province of British Columbia would not be without the hospitalization scheme which we have in operation in this province today.

in a good credit position? Or, are they in the hole?

I would say, relatively speaking, our hospitals are better off today financially than they ever were at any time in their history. And they are providing better services to our citizens. And they have relieved the people of the Province of British Columbia of terrific responsibilities.

COMMISSIONER BAITMAN: You believe that the people are satisfied.

MR. BLACK: I claim -- I think it is my

made of the request that Briefs contain as much statistical and cost data as possible in support of recommendations. We regret that extensive statistical and cost data has not been included in this brief, principally because this information is not available. The absence of good rehabilitation statistics and costs has been dealt with in our submission and a recommendation has been made in this regard which I will present shortly. We also would like to point out that while the G. F. Strong Rehabilitation Centre is a comparatively large institution as rehabilitation centres go, it has limitations in the availability of specialized personnel and personnel time in preparing a Brief of such an extensive nature.

In preparing this Brief, we felt that it was not necessary to sell the concept of rehabiltitation as this has been successfully demonstrated over the past two decades by the Department of Veterans' Affairs, Workmen's Compensation Boards and various voluntary agencies active in the field of rehabilitation. It was our attitude that the Centre's Brief should concentrate on those matters which we regarded as being of particular importance to the development and expansion of rehabilitation services within the frame of reference set out in the letter of Transmittal.

I noted, Mr. Chairman, from the transcript of part of the hearings in Halifax that you requested the definition of the term "comprehensive" that was used in one of the Briefs presented at that hearing. As this is a term frequently used in our submission, I would like at this time to define the connotation that this word has in most cases where it is used in our Brief. The term

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"comprehensive" has a number of acceptable definitions. We have used the word frequently to form phrases, such as "comprehensive rehabilitation", "comprehensive services" and "comprehensive rehabilitation programme" to indicate a rehabilitation programme or service which provides a wide range of integrated services in the medical, psychological, social and vocational areas, centrally located in a controlled environment.

I would like to present the recommendations and points of need. I mentioned previously I have some elaboration to make on five points in the recommendations. The first recommendation:

1. The G. F. Strong Rehabilitation Centre requires Federal and Provincial financial aid to put into action long-delayed plans for the expansion of its over-crowded facilities.

Our Nation's programme for the rehabilitation of the disabled may be regarded as the aggregate of the facilities and services provided at the community level. In regard to this first recommendation I am uncertain as to how this local problem relates to the interest and terms of reference of this National Royal Commission on Health Services. I am certain on the other hand that any general improvement in the rehabilitation management of our Nation's disabled children and adults must have its roots in improved community resources.

2. A comprehensive rehabilitation centre is costly to operate, requires special facilities and equipment, and needs a wide range of highly trained personnel who are in short supply. While generally hospitals require

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2. A comprehensive rehabilitation centre is costly to operate, requires special facilities and equipment, and needs a wide range of highly trained personnel who are in short supply. While generally hospitals requires

physical medicine and rehabilitation services, unnecessary duplication of the comprehensive centre should be avoided as it can efficiently function as the rehabilitation arm of hospitals in the community, particularly for patients requiring extensive rehabilitation service.

3. Comprehensive rehabilitation is a comparatively new but proven aspect of health services and requires accelerated development to narrow appreciably the gap between the need for and the availability of rehabilitation services.

4. Statistics on the need for these comprehensive services are not available. In their absence planning and development must take place on a basis of reasoned judgment, and on consideration of the obviously large number of disabled individuals who might benefit from rehabilitation services.

5. The Federal Government, jointly with Provincial Governments and appropriate voluntary agencies, should establish a research project leading to the development of a national reporting system to collect rehabilitation data.

6. A national association of rehabilitation facilities should be organized, with the help of a Federal grant, to assist in establishing a national reporting system, to develop standards for rehabilitation services and facilities, and to establish a mechanism for accrediting services and facilities.

7. Rehabilitation is effectively accomplished through comprehensive evaluation and services, encompassing the medical, psychological, social and vocational aspects of disability. This type of programme is offered in the comprehensive type centre and if the best use is to be made of available funds and scarce personnel, programmes offering

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limited services should be discouraged except where applicable to a limited need.

8. The shortage of professional personnel is an obstacle to the expansion of comprehensive rehabilitation services and is a deterrent to establishing good standards. Six courses of remedial action are recommended.

This recommendation deals with a key problem in the development of rehabilitation services and one which has no short term solution. Improved legislation and an increased supply of funds will be of little use without adequate personnel to staff rehabilitation facilities. As a small illustration of this problem but one which is repeatedly experienced in many facilities, we would point out that the Centre experienced a delay of 14 months in filling a vacancy for a social service supervisor and 7.1/2 months in filling a vacancy for a vocational counsellor.

9. Increased Federal-Provincial aid is necessary to support existing rehabilitation facilities adequately and to make services available to a larger number of disabled people.

10. Federal-Provincial construction grants should be available for various types of rehabilitation facilities and should be related to the function and design of these facilities rather than related to the function and design of acute or chronic hospitals.

Separate provision for capital grants for rehabilitation facilities also would make it possible to increase the proportion of cost shared by the Federal Government as a means of stimulating the building of new

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Separate provision for capital grants for rehabilitation facilities also would make it possible to increase the proportion of cost shared by the Federal Government as a means of stimulating the building of new

facilities and improving many existing facilities for rehabilitation. Mr. Martin, the Minister of Health Services and Hospital Insurance for this province, has stated in regard to hospital construction that the Provincial Government's share was 50 per cent, the community's share approximately 37 per cent and the Federal Government's share approximately 13 per cent. The current Technical and Vocational Training Agreement existing between this province and the Federal Government provides for cost-sharing in respect of capital costs involved in building vocational schools on a basis of a 75 per cent contribution by the Federal Government and 25 per cent by the Provincial Government to April 1, 1963, when the Federal Government's share will be reduced to 50 per cent. This has had a tremendous impact in priming the development of vocational schools in this Province and a similar agreement would have a favourable effect on the development of rehabilitation facilities.

11. Federal and Provincial authorities should take the initiative to have present and future public buildings made architecturally suitable to accommodate the aged and those confined to wheelchairs. The earliest action possible should be taken to ensure that future schools buildings accommodate disabled children.

Since this brief was prepared, Mr. Chairman, I have received a copy of the publication entitled "American Standard Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped". This publication reflects the Standards approved on October 31, 1961, by the American Standards

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Association. It reads: "A very forward step now in the United States is the development of public buildings of all types which will be accessible to and usable by the physically handicapped. It would be of substantial advantage to have similar standards accepted by Federal and Provincial authorities and accepted as a supplement to the Building Code of Canada."

12. Suitable housing for the severely disabled is urgently required and is an essential part of a well-conceived and adequately supported rehabilitation scheme.

13. Many industrial plants are not suitable for the employment of severely disabled people because of many factors such as stairs leading into the plant. The granting of Federal funds, or allowances in another form to modify industrial plants, work stations or equipment would facilitate the employment of disabled workers.

14. Rehabilitation workshops, the work of which should be closely co-ordinated with the comprehensive rehabilitation centre, are required to prepare some disabled people for employment in business and industry.

15. Sheltered workshops, which will require annual subsidies, are needed for disabled people who cannot meet production norms in industry.

16. Vocational assessment must be part of total rehabilitation evaluation and should take into account significant medical and psychological considerations.

17. Disabled people with the potential to engage in competitive employment should be trained in regular vocational schools. Federal grants should be available to assist approved schools in modifying their

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16. Vocational assessment must be part of some rehabilitation evaluation and should take into account significant medical and psychological considerations.

17. Disabled people with the potential to engage in competitive employment should be trained in regular vocational schools. Federal grants should be available to assist approved schools in modifying their

facilities for the disabled and to stimulate construction of vocational schools serving both disabled and non-disabled students.

Mr. Chairman, after preparing this brief, I became aware of the details of the Technical and Vocational Training Agreement which, as I mentioned previously, provides for a 75 per cent cost-sharing on the part of the Federal Government, which adequately deals with this recommendation with the exception that the agreement should make provision for contribution of cpaital funds to vocational schools other than those operated by the Provincial Government.

18. The development of a multiplicity of job placement services in a community should be discouraged. The Special Placements Division of the National Employment Service should be studied with a view to providing increased staff with special training in order to cope with the special problems experienced by the severely disabled.

19. Rehabilitation, where the goal is to achieve independent living only, can be of substantial benefit to the severely disabled and his family and needs to be developed along with vocational rehabilitation.

20. The Provincial and Federal levels of government should assign to a single Department major leadership responsibilities and functions in rehabilitation.

21. Rehabilitation requires a close relationship with the community and its participation. While increased government support of rehabilitation is necessary,

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this would not negate the important role that the voluntary agency can play in the affairs of the community, nor should it minimize the responsibilities the community must continue to assume for the well-being of its members.

22. Community rehabilitation programmes must be prevention minded and have long-range vision to ensure that today's disabled children are not among tomorrow's unemployable or socially maladjusted people. Further, such programmes should offer an uninterrupted service to disabled children throughout childhood and adult life.

Mr. Chairman, this concludes our presentation of the summary or recommendations and needs.

THE CHAIRMAN: Thank you very much, Mr. Desjardins.

COMMISSIONER FIRESTONE: Mr. Desjardins, in recommendation 5, you suggest that the Federal Government jointly with the Provincial Governments could develop a national reporting system to collect rehabilitation data. What kind of rehabilitation data do you have in mind?

MR. DESJARDINS: I have a broad spectrum of rehabilitation data in mind, not unlike the data that is presently being collected through the Dominion Bureau of Statistics in regard to hospitals across the country. I do not anticipate that this level of reporting would be instituted immediately, but as you may know the Dominion Bureau of Statistics has a part one and a part two statistical return which is filed with the hospitals. Part one is 14 pages long, and has general statistics on facilities and services. Part two is 17 pages long and

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Mr. Chairman, this concludes our presentation of the summary or recommendations and needs.

THE CHAIRMAN: Thank you very much, Mr. Desjardins.

In recommendation 5, you suggest that the Federal Government joining with the Provincial Governments could develop a national reporting system to collect rehabilitation data. What kind of rehabilitation data do you have in mind?

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has all of the financial data.

But, generally, we need some basic data to start with to know what facilities exist in the country, who they are treating, what kinds of disabled people they are dealing with, what services they are offering, and how much money is spent on these things, and something of the results being obtained.

I think this would form a basis on which further data of a qualitative nature could be developed.

COMMISSIONER FIRESTONE: I am just wondering whether in view of the experience you have in this field it might be possible for you to let the Commission have an outline of some of the data which you feel might usefully be collected in more specific detail than it would be appropriate to present on this occasion?

MR. DESJARDINS: I would like to bring to the attention of the Commission that currently in the United States there are two research projects going on of five years duration, each, and they are somewhat in mid-term now. They deal with this specific matter, and I am sure a lot of useful information will come to them in addition to that which we could contribute to the formation of a national reporting system.

COMMISSIONER FIRESTONE: We can, therefore, expect some suggestions from you?

MR. DESJARDINS: Yes, sir.

COMMISSIONER McCUTCHEON: I have only one question, Mr. Desjardins. Your recommendation 7 is that programmes offering limited service should be discouraged except where applicable to limited need. What do you mean

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MR. DEARDING: I would like to bring to the attention of the Commission that currently in the United States there are two research projects going on of five years duration, each, and they are somewhat in mid-term now. They deal with this specific matter, and I am sure a lot of useful information will come to them in addition to that which we could contribute to the formation of a national reporting system.

COMMISSIONER FINKSTONE: We can, therefore expect some suggestions from you?

COMMISSIONER McCUTCHEON: I have only one question, Mr. Dearding. Your recommendation 7 re that programmes offering limited service should be discouraged except where applicable to limited need. What do you mean

by that?

MR. DESJARDINS: First of all, I wanted to make it clear in my brief that the G. F. Strong Rehabilitation Centre was concerned with a comprehensive programme and generally comprehensive programme is essential for catastrophic disabilities which involve problems in medical, psychological, social and educational areas.

There are other programmes of rehabilitation nature which are essential, and should only be supported where these are applicable to a limited need.

In this Province, there is a great deal of discussion going on now relative to the establishing of activation units in general hospitals throughout the province. This is what I would refer to as a limited need.

In these activation units, for example, there would be the treatment of the haemophlegic who would need a limited scope of services, and this, I would suggest, is what I meant by a limited need.

COMMISSIONER McCUTCHEON: Thank you.

THE CHAIRMAN: Thank you very much, gentlemen. The brief is quite comprehensive in its coverage and also in the magnificent work being doneby the G. F. Strong Rehabilitation Centre. We are very happy to have been able to have this submission from you. Thank you very much.

MR. DESJARDINS: I have a copy of the standards I referred to. May I file these as an exhibit to this report?

THE CHAIRMAN: Yes, indeed, if you will.

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THE CHAIRMAN: Thank you very much, gentlemen. The brief is quite comprehensive in its coverage and also in the magnificent work being done by the G. F. Strong Rehabilitation Centre. We are very happy to have been able to have this submission from you. Thank you very much.

MR. DESLAURIERS: I have a copy of the statements I referred to. May I file those as an exhibit to this report?

THE CHAIRMAN: Yes, indeed, if you will.

---EXHIBIT NO. 173A: American Standard Specifications for Making Buildings and Facilities Accessible to and Usable by the Physically Handicapped, October 31, 1961, American Standards Association, Incorporated.

THE CHAIRMAN: We will now recess until nine o'clock tomorrow morning.

---Adjournment.

We have endeavoured to present those matters which, in our opinion, would be of special interest and concern to the Government of Canada and which are based [illegible] services in British Columbia and the particular problems experienced by the G. F. Strong Rehabilitation Centre.

While the complexities of many of the subjects dealt with in this report make possible the formulating of only broad recommendations in a number of instances, we have nevertheless delineated the needs, with the recommendation that they receive detailed study by a committee or committees more extensively qualified for this responsibility. We will be pleased to make available the services of senior, experienced personnel from our Centre to assist in these studies if requested.

Gordon T. Lowther, President.

Mr. Chairman, with your permission, I would like to ask Mr. Desjardins to present the report.

THE CHAIRMAN: Mr. Desjardins.

Mr. DESJARDINS: Mr. Chairman and members of the Committee, in view of the strenuous day you have obviously had maybe it is appropriate to commence with a brief on rehabilitation. My plan in presenting this brief was to deal with the summary and conclusions, to precede that with some introductory remarks and offer some elaboration on five of the points in the summary of recommendations and needs.

I have attempted to process this brief in accordance with your instructions and particular note was

ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

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ROYAL COMMISSION ON HEALTH SERVICES

Proceedings of the hearing held in Vancouver, British Columbia, 23rd day of February, 1962.

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O.J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C.L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

SECRETARY:

MR. N. LAFRANCE

---On resuming at nine o'clock a.m.

THE CHAIRMAN: If you are ready we will come to order and proceed with this submission of the Vancouver Board of Trade.

THE SECRETARY: That will be Exhibit Number 174.

---EXHIBIT NO. 174: Submission of Vancouver Board of Trade.

SUBMISSION OF THE VANCOUVER BOARD OF TRADE

APPEARANCES:

GORDON S. FAHRNI, M.D. ch.M; F.R.C.S. (C)., F.A.C.S.: F.I.C.S., (Hon.)

W.D. STEWART, M.D.; F.R.C.P. (C).

L.E. RANTA, M.D.; D.P.H.

D.A. DENHOLM, B.S.P.

R. UPTON, D.D.S.

A.L. McLELLAN

MR. BRIAN GATTIE

J.C. BROATCH

MR. ROBERT M. CLARK, B. Comm., B.A., A.M., Ph.D.

A.P.W. WATKINSON, B. Comm.

MR. D.T. BRAIDWOOD

MR. BRAIDWOOD: My Lord and lady and gentlemen of the Commission: I have the pleasure this morning by virtue of holding the office of President of the Vancouver Board of Trade of meeting you the Members of the Royal Commission and saying just a few words, if I may, in anticipation of the formal brief which will be presented.

Vancouver Board of Trade, as I am sure many of you are aware, is similar to other boards of trade

[illegible]

THE JUDGE: [illegible] to order and proceed with this consideration of the Vancouver Board of Trade.

THE SECRETARY: This will be Exhibit No. 174.

EXHIBIT NO. 174: Submission of Vancouver Board of Trade.

[illegible]

[illegible] (Cont.)

L.H. PARTTA, M.D., D.P.H.

T.A. CRONKIN, [illegible]

[illegible] D.P.H.

[illegible]

[illegible]

[illegible]

[illegible] ROBERT M. CLARK, K. Comm., B.A., A.M., [illegible]

A.F.W. WALLACE, K. Comm.

MR. J. T. BRADSHAW

MR. EASTWOOD: My Lord and Lady [illegible] Commission: I have the pleasure this morning of [illegible] the office of President of the Vancouver Board of Trade of meeting you the Members of the Royal Commission and saying just a few words, if I may, in anticipation of the formal brief which will be presented.

Vancouver Board of Trade, as I am sure

and chambers of commerce across Canada. We have what in Vancouver we consider to be a very active Board of 2700 or 2800 members. This Board has been in existence for what to us in Vancouver is a long time, seventy-five years, but to some of your people from the East I am sure this makes us look very junior. I might say the Board has been very interested over the years in public matters of all natures and to this end has had the opportunity before of making presentations to Commissions of this nature. Our procedure in these matters is to appoint a committee of members of our Board and our Board is composed not only of business-people in the commercial sense of the word, but professional people, lawyers, doctors, accountants and the like and people of all classes and descriptions are represented in our overall membership. Our procedure is to appoint a committee of people who voluntarily give their services who are specialists in the field and whom we feel, in many instances, many organizations could not employ because of the diversity of experience in all matters. These people give their voluntary services to us, as I am sure they do in other boards and this gives us a composite picture with which we are happy to assist Commissions such as yourselves or other public bodies to whom we make representations.

I might say that this particular committee has been meeting since last October and is composed of a group of men who are eminent in their field in this area and who represent not only the medical profession, but allied professions in the field of economy and education. As a result of their deliberations they have gone through a process of bringing in a recommendation which has

and chambers of commerce across Canada. We have what in Vancouver we consider to be a very active Board of 2700 or 2800 members. This Board has been in existence for what to us in Vancouver is a long time, seventy-five years, but to some of your people from the East I am sure this makes us look very junior. I might say the Board has been very interested over the years in public matters of all natures and to this end has had the opportunity before of making

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in turn gone to our Council of the Vancouver Board of Trade which is composed of about forty or fifty who represent the effective Board of Directors and who in turn have passed on this procedure and material. As a result of that presentation is being made to you here and we thank you for your indulgence in hearing us.

Now, may I introduce the members of the committee who have shown their interest by being here today. On my immediate right Dr. Gordon S. Fahrni who will be the flag-bearer for us and will lead in presenting the brief and, of course, will be available for cross-examination if required. I will introduce the other gentlemen and if they will stand as I introduce them; Dr. Stewart who is Chairman of the Health Committee of the Vancouver Board of Trade. Dr. Ranta who is Associate Director of the Vancouver General Hospital; Mr. Denholm who is Registrar and Secretary-Treasurer of the Pharmaceutical Association of the Province of British Columbia. Mr. Upton who is the Executive Secretary of the College of Dental Surgeons of British Columbia. And Mr. McLellan who is Executive Director of Medical Services Association. Mr. Brian Gattie who is honorary Treasurer of the Vancouver Board of Trade.

Mr. Broatch who is Manager of Personnel and Industrial Relations of the Canadian Fishing Company Limited. Professor Clark is Professor of Economics at the University of British Columbia who has appeared before many Royal Commissions. Unfortunately, Prof. Clark has not been able to come this morning although he has participated in the work of the committee. I understand he is out of town and may be here before the submission is completed.

In turn goes to our guests of the Vancouver Board of Trade which is composed of about forty or fifty who represent the effective Head of Directors and who in turn have passed on this proposed all material. As a result of that presentation is being made to you here and we thank you for your indulgence in hearing us.

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Then we have Mr. Watkinson who is Secretary of the Civic and Governmental Division and Secretary to the Committee on Health Services for the Vancouver Board of Trade.

Now, may I say I think all these members who are here today would be anxious and willing to answer any questions which the Commission may direct to them. I am sure you will understand I am not directly connected with this submission, I am here by virtue of my office. While I will stay with the Commission for a while I hope to be excused shortly because I am a member of the legal profession and have an appointment before the Courts. I thank you very much for this opportunity to present our brief, and I will ask Dr. Fahrni to present the brief.

THE CHAIRMAN: Thank you very much.

DR. FAHRNI: Mr. Chairman and Members of the Royal Commission; you have before you this submission which has been referred to by our President. He has previously covered the first two paragraphs and I would beg leave to read the next three or four or five paragraphs which we think is quite germane to the whole subject and then I suggest going to the conclusions and recommendations and going through them.

In the preparation of this submission we have sought to confine ourselves to phases of health in which we think industry, both management and labour should be particularly interested, but in considering these we have tried to keep in mind the whole picture of the health of the Nation. As such our comments are directed principally to paragraphs (a) (b) (c) (d) (e) and (h) of the Order in Council P.C. 1961-883.

During its hearings across the nation the Royal Commission will hear submissions from other Boards of Trade and Chambers of Commerce as well as the Canadian Chamber of Commerce. Nevertheless, it is advisable to reaffirm the basic precepts upon which our submission is formulated.

In the past Canadians have grown up with a sense of responsibility to provide food, shelter, health needs and personal advancement for themselves and their families through their own efforts. In this responsibility rests freedom to organize their own lives and a moral satisfaction, not only in this privilege, but also in its accomplishment. The psychological stimulus from a challenge met, a job well done is a strong factor in the health of anyone.

We favor perpetuation of this principle in health care with the following supplementary aids:

(a) Co-ordinated government planning at Federal, Provincial and municipal levels, should be encouraged in the recognized fields of infectious diseases, public health and Workmen's Compensation.

(b) Every citizen of Canada is entitled to adequate health care. Where a citizen is unable to meet the cost of adequate health service, government assistance should be available.

(c) Continuation and expansion of existing medical insurance plans can provide for adequate medical care for the great majority of our people.

Today, industry is mindful of the need to participate with employees and government in promoting

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(c) Continuation and expansion of existing medical insurance plans can provide for adequate medical care for the great majority of our people.

Today, insurance is mindful of the need to provide more work employees and government in promoting

the general health of not only the employees but also members of their families. Such a health programme envisages prevention and treatment right through to full rehabilitation and to an occupational health plan.

Preventive medicine has been developed to a reasonably satisfactory level through government planning and co-operation with the medical profession. The care of acute illness also seems to be reasonably satisfactory up to the time of recovery from the primary phases of the disease. Chronic illness which includes disabling conditions following acute illness is not cared for so well.

I suggest now we go back to the conclusions and recommendations:

CONCLUSIONS AND RECOMMENDATIONS

The following is a synopsis of the major conclusions and recommendations of the submission of the Vancouver Board of Trade to the Royal Commission on Health Services:

1. The attainment and preservation of national health is a primary objective of the Canadian people.

2. Individual responsibility towards the provision for and payment of the cost of medical care is an important factor in achieving this objective.

3. We advocate the conjoint action of government and existing voluntary agencies as the best method designed to develop and extend a scheme of health services to serve the Canadian people.

4. It is considered that voluntary organizations, representing the medical profession, employers and employees have amply demonstrated the success of pre-paid medical

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plans in meeting the health needs of a large section of the population. They should be encouraged and expanded, and government aid should be available to those unable to bear the cost of health plan premiums.

5. In the event that a purely voluntary medical care programme is not practical then mandatory medical coverage under approved voluntary medical care plans is suggested as an alternative. (Specified exemptions would be allowed).

6. The present practice of having medical expenses met by government funds should be continued for persons and families in receipt of social assistance or other forms of aid under a means test.

7. The complete financing of a medical care programme out of general government revenues wholly, or partly out of general revenues and partly out of personal income tax is strongly opposed.

8. It is suggested that further reserach is necessary to ascertain more fully the number of individuals without coverage for loss of wages during sickness and non-occupational accidents.

9. There is a great need for a more comprehensive and integrated programme for the care and rehabilitation of those afflicted with disabling conditions. Most of these invalids can and should be helped (at least) to a degree whereby they are able to get about and take care of themselves while many should be expected to progress in recovery sufficiently to resume their previous or some other useful occupation. Because of the lack of such an enlightened programme many of these disabled people lapse into chronic invalidism - a state of boredom for themselves and a burden to their families and society.

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10. It is recommended that the Federal Government take the lead and foster further development in occupational health programmes with particular attention to those designed to serve small industries or groups of small industries.

11. There is need for a special study to define the proper role of commerce and industry in the rehabilitation of the mentally ill especially in view of the greater degree of community-based treatment of the mentally ill which more than formerly leaves such individuals as part of the labour force.

12. There is need for the development of study and an educational programme to define the limits of responsibility of commerce and industry to participate in the treatment and rehabilition of the alcoholic.

13. It is recommended that Federal authorities in their support of provincial hospitalization programmes recognize the need for hospitalization in the treatment of certain stages of alcoholism and thereby create a climate for the more adequate understanding and treatment of alcoholics by the medical and allied professions.

14. It is recommended that Federal authorities give adequate support to study and educational programmes operated by appropriate voluntary agencies in order to define the part that commerce and industry should take in the rehabilitation of the drug addict who is receiving follow-up supervision after undergoing withdrawal therapy.

15. It is recommended that Federal authorities in their support of provincial hospital insurance schemes recognize the need for such hospitalization in suitably supervised

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15. It is recommended that Federal authorities in their support of provincial hospital insurance schemes recognize the need for such hospitalization in authority supervised

areas in general hospitals and in this way encourage the development of a greater understanding among the medical and allied professions of the treatment of the drug addict.

16. During the past few decades life expectancy has greatly increased and there has been a big change in the social and economic life of our country. The result of these vital changes leaves society with a much higher proportion of older people who, largely because of the change in social and economic conditions, are unable properly to integrate their lives with the social stream of the community. This is particularly true in British Columbia where there is a high incidence of elderly people. We would, therefore, stress the need for further study of this whole field with a view to meeting this challenge.

17. In view of the high costs of education in the various health professions and in the event it should be necessary to ensure adequate replacement of trained personnel consideration should be given to alleviating the situation through an increased degree of government subsidization of education in the health field.

18. It is recommended that further studies be carried out in the field of training various health care personnel with a view to improving through concerted government, professional and industrial co-operation the standard of health care to those employed in the industrial community.

THE CHAIRMAN: Thank you, Dr. Fahrni.

COMMISSIONER FIRESTONE: Dr. Fahrni, we have in Canada and in British Columbia a hospital insurance program in operation; how does the Board of Trade

areas in general hospitals and in this way encourage the [illegible] and allied professions of the treatment of the drug addict.

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18. It is recommended that further studies be carried out in the field of training various health care personnel with a view to improving through co-operated government, professions and industries, co-operation the standard of health care to those employed in the industrial community.

MR. CHAIRMAN: Thank you, Dr. Farmer.

We have in Canada and in British Columbia a hospital insurance program in operation; how does the Board of Trade

feel about this program? Has it been an effective program, useful program? Does the Board of Trade approve of the program as it now operates?

DR. FAHRNI: So far as I know I can say that we are in favour of this hospital program.

COMMISSIONER FIRESTONE: This program covers everybody in the Province of British Columbia.

DR. FAHRNI: There are certain limitations, as I understand it.

COMMISSIONER FIRESTONE: Except for those specified limitations it covers everybody in British Columbia.

DR. FAHRNI: As far as I know, it does.

COMMISSIONER FIRESTONE: The payment for this hospitalization program is made out of the taxes paid at the Provincial and Federal level and the general revenue to which taxes contribute except for the $1.00 a day, is that correct?

DR. FAHRNI: Well, I am not an authority on this, but my opinion is that it is.

COMMISSIONER FIRESTONE: Therefore, the Board of Trade has no objection in this field to a health scheme which is largely tax-supported?

DR. FAHRNI: Would you repeat that, sir?

COMMISSIONER FIRESTONE: The hospital field is an important sector of the health field and the Vancouver Board of Trade does not object to a tax-supported scheme, it is largely tax-supported, not quite because of the $1.00 a day contribution.

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Vancouver Board of Trade does not object to a tax-supported

scheme, as is largely tax-supported, but quite because of

the $1.00 a day contribution.

DR. FAHRNI: Speaking for myself and maybe the Health Committee which is composed largely of medical people I would say that is quite a different thing from hospitlization.

COMMISSIONER FIRESTONE: I wonder whether I could restate the question. The hospital insurance program as it now operates in British Columbia is largely paid out of general revenue which is the Provincial Government and the Federal Government contribution through a tax plus a small contribution of $1.00 per day per patient. Now, I take it since you approve of the scheme as it now operates you have no objection to a tax-supported health scheme in this field of hospitalization largely tax-supported?

DR. FAHRNI: In the hospitalization field as far as I know, it has been working reasonably well. I am afraid I am not an authority on the sources of revenue and that sort of thing.

COMMISSIONER FIRESTONE: But the Board of Trade, and I take it you are speaking for the Vancouver Board of Trade, have no objections?

DR. FAHRNI: Speaking for my committee and the doctors concerned I think we have no objections.

Thank you, sir. Now, if I may turn to paragraph 7 of your conclusions and recommendations on the first page. You say the complete financing of a medical care program out of general Government revenues wholly, or partly out of the general revenues and partly out of personal income tax is strongly opposed. Can you explain to us why in the hospitalization field you have no objection

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COMMISSIONER MUNRO: Mr. I wonder

program as it was operated in British Columbia is largely paid out of general revenue which is the provincial Government

tax plus a small contribution of $1.00 per day per patient. Now, I take it sir, you are aware of the scheme as it now

scheme in this field of compulsory-medical insurance tax-supported.

MR. [illegible]: In the [illegible]

CHAIRMAN [illegible]: For the [illegible]

DR. [illegible]: Speaking for my committee

THE WITNESS: Now, if I may turn to paragraph 7 of your conclusions and recommendations on the first page. You say the complete financing of a medical care program out of general Government revenues which, or partly out of the general revenues are partly out of personal income tax is strongly opposed. Can you explain to us why in the hospitalization [illegible] you have no objection

to a program which is largely financed out of tax revenue and why you take the opposite view in the field of medical care services.

DR. FAHRNI: I think, sir, in paragraph 26 of the main submission that our answer is spelled out to some extent there. If you wish me to read it, I will.

THE CHAIRMAN: You may read or paraphrase as you wish, sir.

DR. FAHRNI: I am going to read the first paragraph: " The chief reasons for our opposition to a comprehensive state programme are:

(i) We believe that the temptations for both patients and doctors to overuse the services provided under such a programme would be very great. The experience of the Unemployment Insurance Programme in every province, and of the federal-provincial Disability Allowances Programme in a few provinces, has shown clearly how extremely difficult it is both administratively and politically to prevent the growth of abuses which would add greatly to the cost of the programme.

(ii) A state medical care programme is particularly open to abuse if it is financed solely out of general government revenues or even partly out of general revenues and partly out of the personal income tax. Under either of these alternatives there is for most households insufficient correlation between the extent they use the state services and the cost to them of these services. The majority of Canadian families are both able and willing to meet

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their medical expenses. Apart from those needing financial assistance to pay their bills, we believe that the fairest basis is through the payment of premiums related to the utilization of the medical services by the groups covered.

(iii) A state medical programme, especially if doctors are paid on a straight salary or a capitation basis, would disturb the doctor-patient relationship in many cases, and give doctors less financial incentive than most of them now have to do their best work for their patients.

What I mean by that, is people are going to be happy in their work, that is why we think in this financial thing the doctor must have some stimulus to do the best work possible.

COMMISSIONER FIRESTONE: As I understand the first objection you are raising in second paragraph (i) in paragraph 26 is the danger of overutilization. How would you visualize such overutilization to take place?

DR. FAHRNI: Well, I am going to speak personally on this, sir. I think I am speaking for everybody as well, that if there are no financial responsibilites on anybody they will tend to overuse it. I think that is a truism.

COMMISSIONER FIRESTONE: Could we look into the practical aspects, how this would occur: Somebody would go to his doctor and say to the doctor, "I don't feel well, will you please examine me". The doctor would examine him and say, "Well, you are not very seriously sick, give him something innocuous and send him home". Would you

financial assistance to pay their bills, we believe that the future health is through the payment of premiums related to the utilization of the medical services by the groups covered.

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[illegible]

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COMMISSIONER FINKSTOWN: Am I understand the first objection you are making is second one

[illegible]

How would you visualize such an institution to take place?

Dr. [illegible]: Well, I am going to speak personally on this, sir. I think I am speaking for everybody as well, that if there are no financial responsibilities on anybody they will tend to overuse it. I think there is a trend.

COMMISSIONER FINKSTOWN: Could we look into the practical aspects, how this would occur: Somebody would go to his doctor and say to the doctor, "I don't feel well, will you please examine me". The doctor would examine him and say, "Well, you are not very seriously sick, give him something innocuous and send him home". Would you

consider that overutilization?

DR. FAHRNI: I would consider that very, very bad medicine.

COMMISSIONER FIRESTONE: What happens in private practice at the present time when people come down and think they are sick, the doctor in his wisdom may feel they just imagine it. I presume this happens now, you don't have to have state medicine for this to happen.

DR. FAHRNI: I think what happens now, the doctors have their own patients pretty much, and they are able to visualize the situation pretty well whether a person is psychologically upset, emotionally upset, there is nothing much they can do for them but try to pacify them. If people are not paying for their own services they will tend to take up a lot of his time and he feels he is getting nowhere with him. That is what we have in medicine, in other words, a doctor is trained to look after the sick. If people are not really sick he doesn't like to have his time taken up by people who should not be there and are not sick enough. I don't mean to suggest that people who are emotionally disturbed should not be treated. Please get me right. We do feel a lot of people, I think this is history in other countries, I know in the old country it has been where the doctors offices were crowded with people who had nothing very much wrong with them.

COMMISSIONER FIRESTONE: Wouldn't you feel, sir, this matter could be left to the judgment of the physician and the physician in his wisdom wouldn't want to overutilize the service.

DR. FAHRNI: It would be a lot of

pressure on the physician.

COMMISSIONER FIRESTONE: The physician is the man who treats the patient and we would have to rely on his judgment, wouldn't we, sir?

DR. FAHRNI: Always, sir.

COMMISSIONER FIRESTONE: I was just wondering whether we could ask a member of M.S.A. who is with you, sir, whether there is, in fact, much overutilization on the scheme that is in operation here in Vancouver. M.S.A. covers as we were told something like one half million people. I understand there was very little overutilization and where overutilization occurred there was machinery to deal with it.

DR. FAHRNI: Mr. McLellan, I believe could answerthat.

MR. McLELLAN: Dr. Firestone, you will realize with the operation of this plan in British Columbia on an experience-rated basis these people, sooner or later get the idea that they are using their own money and it is social pressure of that group that keeps them in line. To over-simplify this question there are some people who think, if they steal a ride on the railroad, that is not stealing, so when you get this financing in that situation you have lost the individual responsibility that the patient has, the individual responsibility to the group or the individual that this is his own money that he is spending. If it comes out of taxes it is very difficult to have a subscriber get into that. Does that answer your question?

COMMISSIONER FIRESTONE: Yes, in part, but in your Association you have developed under M.S.A. a

COMMISSIONER FIRESTONE: I was just with you, sir, without there is, in fact, much overutilization in M.S.A. covers as we were told something like one half million people. I understand there was very little overutilization and where overutilization occurred there was

DR. RAHUNI: Mr. McLellan, I believe on an experience-rated basis these people, somehow or larger get the idea that they are using their own money and is several pressure of that group that keeps coming into, to overmany times a wide on the millions, that is not starting, when you get this flowering in that situation you have lost the individual responsibility that the patient has, the individual responsibility to the group or the individual that this is his own money that he is spending. If it get into that. Does that answer your question?

but in your Association you have developed under M.S.A. a

system to control overutilization, have you?

DR. McLELLAN: Yes, sir.

COMMISSIONER FIRESTONE: Can you explain what system you use?

MR. McLELLAN: There are two methods by which this is done, the pressure of the group itself in relation to the premiums if they are getting out of line. This is brought to the attention of the union or the management or jointly, and they conduct a campaign to make their people be reasonable. It works. If there is the other situation where a doctor may be guilty of overutilization and is caught in a practice as compared with other doctors in his field, if he is much above the average then persuasion is used to have him conform. Those are the two methods that are used. You can lecture people all day long and until you touch their pocketbooks you don't get anywhere.

COMMISSIONER FIRESTONE: That is very helpful. What I would like to ask Dr. Fahrni, now we have heard that explanation, if overutilization were left to the discretion of the physician we could expect in most cases the physicians would practice medicine under a state-supported scheme the same way they practice under a private scheme, but in case there would be overutilization of the type that was described could not some sort of machinery as far as the physicians are concerned be used in some cases of overutilization. If the machinery is available it could be dealt with under one system as well as under another.

DR. FAHRNI: It still depends, sir, as we know it, as I know it in a private practice you have got

COMMISSIONER FARRENWH: Can you explain what system you use?

MR. MOLENDAN: There are two methods by which this is done, the pressure of the group itself in relation to the premiums if they are getting out of line. This is brought to the attention of the union or the management or jointly, and they connect a campaign to make their people be reasonable in works. If there is the other situation where a doctor may be guilty of overutilization and is caught in a practice as compared with other doctors in his field, if he is much above the average then persuasion is used to have him conform. These are the two methods that are used. You can lecture people all day long and until you turn white pathetic you don't get anywhere.

COMMISSIONER FARRENWH: Thank you very much. Mr. Molendan, I would like to ask Dr. Barnett, now we have heard that explanation, if overutilization were left to the discretion of the physician we could expect in most cases the physicians would practice medicine under a state-supported scheme the same way they practice under a private scheme, but in one there would be overutilization of the type that was described could not come out of machinery as long as the physicians are concerned be used in some cases of overutilization. If the machinery is available it

DR. BARNETT: It really depends, sir, as we know it, as I know it in a private practice you have got

your own practice and that sort of thing and you are interested in your patients particularly, in individual patients. You want to get right to the heart of the trouble and are trying to cure them. If you are going to be put in a position where your office is overloaded by a lot of people that are not particularly sick you haven't got time to do anything well. That is one of my chief objections.

COMMISSIONER FIRESTONE: Presumably, in due course it may be possible to increase the number of physicians in the country so that the burden would be more widely spread. I can see you have a good point. I can see it in the initial period there might be some overloading. That point is well taken, sir.

May I turn to sub-paragraph 2 unless you have something to add.

DR. FAHRNI: No.

COMMISSIONER FIRESTONE: I would like to turn to sub-paragraph 2 of paragraph 26 in which you state the fairest basis is through the payment of premiums related to the utilization of the medical services by the groups covered. If I understand your proposal, you feel, and I put it to you in my own words, please correct me if I did not understand it quite adequately, that your views are that a program of the order we are discussing should be paid by those that could afford to pay through premiums and those that cannot afford the premiums would be paid by the state. Am I correct in that understanding?

DR. FAHRNI: I think so, sir.

THE CHAIRMAN: Dr. Fahrni, we might

[illegible] practice an that sort of thing and you are interested in your patients particularly, in individual [illegible] [illegible] [illegible] to cover them. If you are going to be put in a position where your office is overloaded by a lot of people that are not particularly sick you haven't got time to do anything well. That is one of my chief objections.

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Dr. HAHNI: No.

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Dr. GRAHAM: Dr. Hahni, we might

mention as questions are put they are directed to you as spokesman, but they may be answered by anyone of your group as you see fit.

MR. GATTIE: Mr. Chairman, I would like to mention it is my understanding that the hospitalization fund is derived from a sales tax in this province to a very large degree, anyway. Personally, I don't regard sales tax as being general taxation. It is taxation, but it is not the same as taking money out of income tax, if you like. Nor do I think that the general practice of medicine is to be compared equally with hospitalization. I don't know the percentage of the general public that goes into the hospital, but there are people, I fortunately am one of them that haven't been inside a hospital for anything of major importance. I would have contributed in the time the hospital plan was in force a further premium in the sales tax I have paid on goods that I have bought. I cannot see much difference between financing of the hospitalization plan and the financing of a medical care like M.S.A. I feel one wouldn't feel happy if a hospital plan -- you made a comparison of the two conditions, medical hospital and general practice, I wouldn't go for that as one member of the panel.

COMMISSIONER FIRESTONE: You would say, sir, that if the pre-paid medical care plan would, in part be paid through a higher sales tax you would have no objections to that?

MR. GATTIE: I think that would be more palatable. It is less a form of direct taxation. You can contribute to sales tax or not. If you want to buy your

fund is derived from a sales tax in this province to a very large degree, anyway. Personally, I don't regard sales tax as being general taxation. It is taxation, but it is not the same as taking money out of income tax, if you like. Nor do I think that the general practice of medicine is to be compared equally with hospitalization. I don't know the percentage of the general public that goes into the hospital, but there are people, I fortunately am one of them that haven't been inside a hospital for anything of major importance. I would have contributed in the same

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and general practice. I wouldn't go for that as one member

of the panel.

CHAIRMAN: Yes, would you.

MR. GRAYER: I think that would be more

palatable. It is less a form of direct taxation. You can

conceivably do either one or two. If you want to buy your

wife a fur coat you are going to pay a big chunk of money into the hospital fund.

COMMISSIONER FIRESTONE: It isn't a matter of objection in principle, but it is an objection to paying it through certain taxes and you mentioned income tax, is that your point, sir?

MR. GATTIE: I don't know the general revenues of the country should be used. I mean there is no option in the plan. There is an option on the sales plan.

COMMISSIONER FIRESTONE: Presumably, the sales tax when collected goes into general revenue.

MR. GATTIE: I don't know whether it does or not. It is called the hospital sales tax. How much finds its way to the hospitals I am not in a position to say. It is political.

COMMISSIONER FIRESTONE: The taxes that are collected form part of the Government's general revenue and a certain proportion goes back to the hospital. That is how it works in practice.

MR. GATTIE: I suppose that is how it works in practice.

COMMISSIONER FIRESTONE: May I now turn to sub-paragraph (c) of paragraph 26. You say if doctors are paid on a straight salary or a capitation basis it would disturb the doctor-patient relationship in many cases and give doctors less financial incentive than most of them now have to do their best work for their patient. If there were in existence, Dr. Fahrni, a tax-supported medical care service and the payments to doctors were on a

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COMMISSIONER FIREHOUSE: May I now go to sub-paragraph (c) of paragraph 26. You say if doctors are paid on a straight salary or a capitation basis it would disturb the doctor-patient relationship in many cases and give doctors less financial incentive than most of them now have to do their best work for their patients. If there were in existence, Dr. Bahnan, a tax-supported medical care service and the payments to doctors were on a

fee for service basis, would that be acceptable?

DR. FAHRNI: Could I ask Dr. Stewart, if I may, Mr. Chairman, to reply to that. He is Chairman of our Health Committee.

COMMISSIONER FIRESTONE: Thank you very much.

DR. STEWART: Any answer to such a question must be in part at least personal and postulated too. What causes this incentive for a doctor to do his best work, there is a relationship between the person who is paying from his own pocket a certain amount for the service, that makes up the relationship, shall we say, between the doctor and the patient aside from the normal aspect of it. I think to introduce a third policy, be it Government or other, would reduce this particular relationship.

COMMISSIONER FIRESTONE: Let us assume for a moment that such a scheme would consist of financial contribution made by the Federal Government and the Provincial Government and the Provincial Government would designate as its carrier a combination of M.S.A. and M.S.I. the sort of group that is already in the field, that has the experience, has the confidence of the medical profession would you still say the physician would face the difficulties that you have just described?

DR. STEWART: It is hard to visualize such an arrangement.

COMMISSIONER FIRESTONE: I may say it has been proposed to us in other provinces. I am trying to see if the same principle were applied in British Columbia how the Board of Trade would feel about it.

fee for service basis, would that be acceptable?

DR. BARNETT: Could I ask Dr. Stewart, if I may, Mr. Chairman, to reply to that. He is Chairman of our health committee.

COMMISSIONER FINNEMORE: Thank you very

DR. STEWART: Any answer to such a question must be in part at least personal and psychological, I do. What causes one incentive for a doctor to do his best work. There is a relationship between the person who is paying from his own pocket a certain amount for the service that makes up the relationship, that I say, between the doctor and the patient, aside from the moral aspect of it. I think to introduce a third party, be it government or

COMMISSIONER FINNEMORE: Let us assume for a moment that such a scheme would consist of financial contribution made by the Federal Government and the Provincial Government and the Provincial Government would designate as the member a combination of M.S.A. and M.S.I. The sort of group that is already in the field, that has the experience, has the confidence of the medical profession would you really say the physician would find the difficulties where you have just described?

DR. STEWART: It is hard to visualize such an arrangement.

COMMISSIONER FINNEMORE: I may say it has been proposed to us in other provinces. I am trying to see if the same principle were applied in British Columbia now the board of trade would feel about it.

DR. FAHRNI: Mr. Broatch.

MR. BROATCH: If I might, Dr. Firestone, I would think it would be detrimental in this regard; Mr. McLellan mentioned the fact that there was a deterrent because of group pressure. If there was a contract with M.S.I. or M.S.A. everyone in that particular group or that particular Company or that particular industry is sharing a portion of the bills which are accumulated by the group. There is pressure from the other employees, the other workers in that group to hold costs down and the fact if they don't hold costs down they are going to pay more for it is a deterrent in that case. If the Government were paying the bill you would lose that deterrent. That would be my reaction to this question.

COMMISSIONER FIRESTONE: It is a very helpful answer only it doesn't deal with the question I have raised. My question related to sub-paragraph (c) of number 26 where we were talking about how the physician is being paid. This paragraph suggests that the Board of Trade objects to either straight salary or a capitation basis. My question was if the arrangement were payment on a fee for service basis, would that be acceptable?

MR. BROATCH: Certainly I would feel it would have to be on a fee for service basis, sir.

DR. FAHRNI: I wonder if I could make a remark on that, capitation and salary. In paying doctors on capitation or salary basis, it gets away from the payment for services idea.

In other words, if you feel you are doing a job for a person, and you are going to be paid

MR.

I would think it would be [illegible]

Mollelier mentioned the fact that there was a deterrent because of group pressure. If there was a contract with M.S.I. or M.S.A. everyone in that particular group or the particular company or that particular industry is aware of a portion of the bill which are recommended by the group. There is pressure from the other employees, the owner workers in that group to help cutte down on the fraud if they can. I hate cutte down day are going to pay more for it is a detriment in most cases. If the government was paying the bill you would have the deterrent. That would be my reaction to such question.

COMMISSIONER HIRSCHMAN: It is a very helpful answer only it doesn't deal with the question I have raised. My question related to sub-paragraph (d) on number 26 where we have a long, short form provision in being paid. This paragraph suggests that the Board of Trustee objects to either straight payment or a capitation basis. My question was if the arrangement were payment on a fee for service basis, would that be acceptable?

MR. SHORTER: Personally I would feel it would have to be on a fee for service basis, sir.

DR. TAMBURI: I wonder if I could make a remark on that, considering the salary in paying doctors on capitation or salary basis, it goes away from the payment for services rendered.

In other words, if you feel you are taking a job for a person, and you are going to be paid

accordingly, we think it is an incentive.

THE CHAIRMAN: To do better work.

COMMISSIONER FIRESTONE: The obvious question is that if we accept that, what objection have you to a fee for service basis. He is not asking you to approve of capitation. He says if you throw that out the window, now what do you think of fee for service basis? That is, under a tax-supported plan.

DR. FAHRNI: I would think that -- do you want to answer that, Dr. Stewart?

DR. STEWART: The fee for service aspect of it, I would presume, would be acceptable, although I cannot speak as a representative of the Medical Association, but the fee for service aspect of it would be acceptable, although the tax-supporting of the system itself we have gone over in the past two paragraphs.

COMMISSIONER FIRESTONE: On this tax-supported, I understood if this tax-supported would be out of sales tax, there would not be the same objection, if I understood you correctly?

DR. STEWART: I think Mr. Gattie spoke for himself.

THE CHAIRMAN: If I might make an observation through you, Mr. Braidwood, and it is a view that we are putting forward from this table that in the submission, this submission from the Board of Trade, the way you have made it up is that the Board of Trade appears to have handed the situation over to a committee of doctors, principally, and that what we have here is merely an extension in a way of the submission made by the British

accordingly, we think it is an incentive.

THE CHAIRMAN: To do better work.

COMMISSIONER FIRESTONE: The obvious question is that if we accept that, what objection have you to a fee for service basis. He is not asking you to approve of capitation. He says if you throw that out the window, now what do you think of fee for service basis? That is, under a tax-supported plan.

DR. MAHONEY: I would think that -- do

DR. STEWART: The fee for service aspect of it, I would presume, would be acceptable, although I cannot speak as a representative of the Medical Association, but the fee for service aspect of it would be acceptable, although the tax-supporting of the system itself we have gone over in the past yesterday.

COMMISSIONER FRANCHER: On this tax-supported, I understood if this tax-supported would be out sales tax, there would not be the same objection. If I

THE CHAIRMAN: If I might make an observation through you, Mr. Braidwood, and it is a view that we are putting forward from this table that in the submission, this submission from the Board of Trade, the way you have made it up is that the Board of Trade appears to have handed the situation over to a committee of doctors, principally. And what what we have here is merely an extension in a way of the submission made by the British

Columbia Division of the Canadian Medical Association, and that what we really are interested in having from chambers of commerce, boards of trade, and the business organizations, the business community, is the viewpoint of business as such, and not of its medical section.

I mean that we are having a recap here this morning of the questions and answers dealt with on Tuesday morning when the British Columbia Section of the Canadian Medical Association was before us. We have exactly the same responses, I mean, viewpoints. We are interested to know the views of business as such, of banks, of generally the commercial world, industry, and just as we were interested in having the views of labour, or of consumer groups.

I mention that because your brief does appear to be an extension or a sort of addenda to the medical brief.

Now, if in the light of that you would like to make a further submission to us in writing, we would be very happy to have it. That is, not putting yourselves forward as a spokesman again for the medical profession, but as a spokesman for the business community as a whole.

Now, this is not a lecture nor a criticism, but I am referring to the value that we can hope to expect and receive from a submission for a body that is so representative of the commercial world and business world as the Vancouver Board of Trade.

Do you think that in the light of what I have said that you can be of any further help to us, Mr.

Division of the Canadian Medical Association, and that what we really are interested in having from chambers of commerce, boards of trade, and the business organization the business community, is the viewpoint of business as such, and not of its medical section.

I mean that we are having a group here this morning of the questions and answers dealt with on Tuesday morning when the British Columbia section of the Canadian Medical Association was before us. We have exactly the same responsibilities, I mean, viewpoints. We are interested to know the views of business as such, of people, of persons in the commercial world, industry, and just as we were interested in hearing the views of labour, or of consumers groups.

I question whether perhaps your brief does appear to do so in exactly the same of sort that is the one I have before.

Now, if I can get light of what you would like to see a further amendment to us in writing, we would be very happy to have it. Just by putting your views forward as a spokesman again for the modern private sector, but as a spokesman for the business community as a whole.

Now, this is not a question nor a criticism, but I am referring to the value that we are hope to expect and receive from a submission from a body that is so representative of the commercial world and business world as the Vancouver Board of Trade.

Do you think that in the light of what I have said that you can be of any further help to us, Mr.

Braidwood?

MR. BRAIDWOOD: Well, I have your remarks, sir, and I appreciate them. As I have said, I have not been personally associated with the work as a committee member of this particular committee. I will take your remarks under advisement, and it may well be that something will flow from them. You have very kindly given us leave to file an additional memorandum on that, and I hope that that would be done, and I would see that it would be done.

I might say, sir, with deference that it appears to me from an examination of the men who served on the committee that a number of these men are not engaged directly or even indirectly in the medical profession. I would also say, sir, that it may well be, and I only make this as a supposition, and it could only be verified on further inquiry, that the view of the average businessman may be coindidental with that of the medical profession, and that may be the reason why, sir, the brief is presented in its present form. I make that only as a supposition.

THE CHAIRMAN: We are pleased to have these distinguished representatives of the medical profession, of course.

MR. BRAIDWOOD: I mean, I quite understand and I well understand your Lordship's view as to what the Commission wants beyond what is here, and I shall see that that is looked into at once.

THE CHAIRMAN: You see, there are economic aspects and financial aspects, aspects of taxation, these kind of things that we would like to discuss with

[illegible] have not been personally associated with the work as a committee member of this particular committee. I will take your remarks under advisement, and it may well be that something will flow from them. You have very kindly given us leave to file an additional memorandum on that, and I hope that that would be done, and I would see that it would be done.

I might say, sir, with deference that it appears to me from an examination of the men who served on the committee that a number of them are not engaged directly or even indirectly in the medical profession. I would also say, sir, that it may well be, and I only make this as a supposition, and it could only be verified on further inquiry, that the view of the average businessman may be antithetical with that of the medical profession, and that may be the reason why, sir, the brief is presented in its present form. I make that only as a supposition.

THE CHAIRMAN: We are pleased to have these distinguished representatives of the medical profession, of course.

MR. DRUMMOND: I mean, I quite understand and I will understand your Lordship's view as to what the Commission wants beyond what is here, and I shall see then that is looked into at once.

THE CHAIRMAN: You see there are economic aspects and financial aspects, aspects of training, these kind of things that we would like to discuss with

people who are very knowledgeable in those fields.

MR. BRAIDWOOD: Well, certainly, I know that the members of the committee who are presently on it and who are not necessarily associated with the medical profession would make an excellent liaison with their counterparts in business to probably further the investigation which the Commission would require.

Dr. Clark, I am quite sure, and I am sure he is very well known to the Commission, and he is an advisor to the Federal Government in taxation matters and the like -- Dr. Clark, I am sure, has explored the economics of this field and I speak with only modest knowledge of the committee's work, as such. I am sure he has, but I will pursue that aspect with him.

Mr. Gattie is a financial man of some considerable stature in our community, and I am sure he can explore the field further, and it might well be that our tax people could have something useful to add.

THE CHAIRMAN: You see, one of the major problems with this Commission necessarily has to face if we are going to recommend any program, the next thing is how much is it going to cost; where is the money going to come from.

MR. BRAIDWOOD: Well, I have your remarks, sir, and I shall follow them out.

DR. FAHRNI: I wonder if I may make a statement just to the effect that this committee, our health committee, consists of not doctors alone, but others. Last September or October, the question arose whether or not the Board of Trade would make a submission to this Commission.

[illegible] Well, certainly, I know

[illegible]

profession would make an excellent liaison with their counterparts in business to probably further the investigation which the Commission would require.

Dr. Clark, I am quite sure, and I am sure he is very well known to the Commission, and he is an advisor to the Federal Government on taxation matters and the like -- Dr. Clark I am sure, has explored the economics of this field and I speak with only modest knowledge of the committee's work, as much [illegible] I am sure he has, but I will pursue that subject with him.

Mr. Smith is a financial man of some considerable stature in our community, and I am sure he can explore the field further, and it might well be that our tax people could have something useful to add.

THE CHAIRMAN: You see, one of the major problems with this Commission necessarily has to face if we are going to recommend any program, the next thing is how much is it going to cost; where is the money going to come from.

[illegible]

marks, sir, and I shall follow them out.

DR. [illegible]: I wonder if I may make a [illegible] committee, members of not doctors alone, but others. Has September or October, the question arose whether or not the Board of Trade would make a submission to this Commission.

I think that your health committee put a little pressure -- not put any pressure, but advised the executive of the Board of Trade that they thought we should do something about this, and this committee was struck. For your information, sir, just to keep the record clear, we have not worked in any way with any other medical organization, and this group have worked this thing out themselves. Whereas it may appear that there is a good deal of similarity in some recommendations to those of the B.C. Division of the Canadian Medical Association, there was no collusion whatsoever. I would like to make that statement.

THE CHAIRMAN: It is not a matter of collusion, and that is not the suggestion we make at all. It is just the essential approach to the study that you made. What we want to hear, I mean to say, the views we want to hear, if there are views worthwhile to be put forward, for the Board of Trade, as such, to come forward with its views.

MR. BRAIDWOOD: May I ask what time element is involved in your deliberations?

THE CHAIRMAN: We will be having public hearings right into May, and certainly -- we start in Toronto the 7th of May -- and I think it is either in Toronto or perhaps it is in Montreal -- I do not know whether Mr. Lafrance can tell me whether it is in Toronto or in Montreal that the Canadian Chamber of Commerce is coming with its main submission.

THE SECRETARY: No, I cannot tell you, sir.

THE CHAIRMAN: It is either in Toronto

[illegible] thought we should do something

[illegible] sir, just to keep the record clear, we have not worked in any way with any other medical organization, and this group have worked this thing out themselves. Whereas it may appear that there is a good deal of similarity in some recommendations to those of the C.C. Division of the Canadian Medical Association, there was no collusion whatsoever. I would like to make that statement.

THE CHAIRMAN: It is not a matter of collusion, and that is not the suggestion in your brief. It is just the essential approach to the study that you made. What we want to know, I mean to say, the reason we [illegible] in these two views [illegible] towards the bring [illegible], as such, to come forward with the views.

MR. DRAWOOD: May I ask one line element is involved in your co-insurance scheme?

THE CHAIRMAN: We will be having public hearings right into May, and certainly -- we start in Toronto the 7th of May -- and I think it is either in Toronto or perhaps it is in Montreal -- I do not know whether Mr. Lafrance can tell me whether it is in Toronto or in Montreal that the Canadian Chamber of Commerce is coming with its main submission.

THE SECRETARY: No, I cannot tell you.

THE CHAIRMAN: It is either in Toronto

or Montreal.

MR. BRAIDWOOD: We would have at least two months, anyway, to file further material?

THE CHAIRMAN: Yes.

COMMISSIONER FIRESTONE: Would it help, Mr. Chairman, if I were to outline three or four questions that you may wish to consider and let us have the considered views of the Board of Trade in your subsequent submission, so that we can get the full views of the Vancouver Board of Trade on some economic and financial questions that bear on the proposals contained in your own brief?

Would it help if I were to outline just the questions, without asking for any answers at this stage, but hoping to get some answers when you make a subsequent submission?

MR. BRAIDWOOD: Very much, sir.

COMMISSIONER FIRESTONE: You speak in paragraph 5 of mandatory medical coverage under approved voluntary medical care plans as an alternative to a full state plan.

What I would hope you could explain to the Commission is what your definition is between mandatory and compulsory.

And, sir, the second question that would be helpful to explain to us concerns your recommendation in paragraph 4 of your recommendations, which says, and I quote:

"Government aid should be available to those unable to bear the cost of health premium."

It would be helpful to us if you were

Mr. Chairman, if I were to outline three or four questions that you may wish to consider and let us have the considered views of the Board of Trade in your subsequent submission, so that we can get the full views of the Vancouver Board of Trade on some economic and financial questions that bear on the proposals contained in your own brief?

Just the questions, without asking for any answers at this stage, but hoping to get some answers when you make a subsequent submission.

CONSIDERATIONS FINANCIAL: You speak in paragraph 2 of mandatory medical coverage under approved voluntary medical care plans as an alternative to a full state plan.

What I would hope you could explain to the Commission is what your definition is between mandatory and compulsory.

Would be helpful to explain to us concerning your recommendation in paragraph 4 of your recommendations, which says, and I quote:

to explain to us how this Government aid should be paid for -- by the Federal Government or the Provincial Government, out of general revenue, out of particular taxes, corporation tax, income tax, sales tax, etcetera.

The next question relates to paragraph 16 of your recommendations, where you refer to the high incidence of elderly people. You suggest in this paragraph that the Province should be studied further with a view to meeting this challenge.

We would appreciate greatly if we could have some specific recommendation from the Board of Trade as to how this problem can be met and it is, perhaps, the most serious problem in any province in Canada, because of the age distribution of your population. If this problem is most serious in British Columbia, we would welcome suggestions from the Province that is most directly affected by it.

What we need in the Commission is the complete recommendations, so that we can either accept them or perhaps vary them, but at least we will have your advice and your judgment.

The next question relates to paragraph 17 in which you recommend that there is need for Government to contribute to the high cost of education in the various health professions and you recommend an increased degree -- and I am quoting now: "An increased degree of Government subsidization of education in the health field."

Would it be possible for you to outline to us what form these Government subsidies should take? Do you have in mind capital or operating grants to medical

to explain to us how this Government and should be paid for -- by the Federal Government or the Provincial Government, out of general revenue, out of particular taxes.

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The next question relates to paragraph 17 in which you recommend that there is need for Government to contribute to the high cost of education in the various health professions and you recommend an increased degree -- and I am quoting now: "an increased degree of Government subsidization of education in the health field."

Would it be possible for you to outline to us what form these Government subsidies should take? Do you have in mind capital or operating grants to medical

schools and other schools of health professions? Do you have in mind scholarships, bursaries at the undergraduate level, at the graduate level? If so, what amounts are involved and how many of these scholarships, bursaries, et-cetera would you recommend? We would appreciate greatly specific recommendations so that they can be considered carefully by the Commission.

Thank you very much, sir.

THE CHAIRMAN: Thank you, gentlemen. We do not want you to think that we put this forward by way of a lecture, but we do seriously ask that you consider much more than the medical aspects and the physician-doctor aspects of the problem in terms of being a business organization, as you are.

MR. BRAIDWOOD: I think I might say, Mr. Chairman, that the Board is familiar with the Canadian Chamber brief and has examined it, too, and we will re-examine it again in line with your statements here.

THE CHAIRMAN: Yes, thank you.

COMMISSIONER FIRESTONE: We do appreciate any special views you have which affect the British Columbia situation.

MR. BRAIDWOOD: Thank you, sir.

[illegible] now proceed [illegible] Greater Vancouver [illegible].

THE CHAIRMAN: The next brief is that of the Community Chest and Councils of the Greater Vancouver Area.

THE SECRETARY: The sumission will be

[illegible] bursaries at the undergraduate [illegible] graduate level? If so, what amounts are involved and how many of these [illegible], bursaries, etc. [illegible] would you recommend? We would appreciate greatly specific recommendations so that they can be considered carefully by the Commission.

Thank you very much, sir.

THE CHAIRMAN: Thank you, gentlemen. We do not want you to think that we put this forward by way of a lecture, but we do seriously ask that you consider much more than the medical aspects and the physician-doctor aspects of the problem in terms of being a business organization, as you are.

MR. BRAITHWOOD: I think I might say, Mr. Chairman, that the Board is familiar with the Canadian Chamber brief and has examined it, too, and we will re-examine it again in line with your observations.

THE CHAIRMAN: Yes, thank you.

GENTLEMEN, PROFESSOR: We do appreciate any special views you have which affect the British Columbia situation.

MR. BRAITHWOOD: Thank you, sir.

[illegible]

THE CHAIRMAN: The next brief is that of the Community Chest and Councils of the Greater Vancouver [illegible]

MR. SECRETARY: The summation will be

Exhibit 175, and the attached material will be Exhibit 175 A.

---EXHIBIT NO. 175: Submission of Community Chest and Councils of the Greater Vancouver Area.

---EXHIBIT NO. 175A: Attached material to above brief.

S U B M I S S I O N O F

COMMUNITY CHEST AND COUNCILS OF THE GREATER VANCOUVER AREA

APPEARANCES:

MRS. C.W. MELLISH

MISS AMY LEIGH

MR. CH.H. NAPHTALI

MR. E.D. HILL

MR. GIBB HENDERSON

DR. K.C. BOYCE

MISS C.W. PERKINS

MR. A.A. BOUCHER

MRS. RHONA LUCAS

MRS. M.H. GINSBERG

MRS. KAE McKENZIE

MRS. R.F. BRUCE TAYLOR

MR. B.A. ROBINSON

MR. R.C. NANN

MR. N.T. BEAUPRE

MR. BEAUPRE: Mr. Chairman, we are rather a large delegation and I do not know that this requires an excuse, but we do represent some 11,000 volunteers; maybe that gives some measure to explain our numbers.

EXHIBIT 175, and the aldermen material will be Exhibit 175 A.

---EXHIBIT NO. 175: Submission of Community Church and Council of the Bruton.

S U B M I S S I O N O F

COMMUNITY CHURCH AND COUNCIL OF THE CHURCH VANCOUVER ATT.

ADDRESSED:

MRS. G.W. MELLION

MISS AMY LEIGH

MR. R.D. HILL

MR. A.G. BOYCE

MISS C.W. PENNING

MRS. ROSA LUCAS

MRS. M.E. GINSBERG

MRS. KAS McKINSIT

MRS. R T. BRUCE TAYLOR

MR. R.A. ROBINSON

Mr. H.T. MAGNUS

MR. TREASURE: Mr. Chairman, we are rather a large delegation and I do not know that this requires

I would like to introduce my colleagues and explain to you their position on our delegation.

GENERAL REPORT and RECOMMENDATIONS

Mrs. C.W. Mellish (Committee Chairman)

Miss Amy leigh (Consultant)

Mr. C.H. Naphtali (Executive Director)

Mr. E.D. Hill (Director of Planning)

HEALTH DIVISION REPORT AND RECOMMENDATIONS

Mr. Gibb Henderson (Division Chairman)

Dr. K.C. Boyce (Planning Associate - Health)

Miss C.W. Perkins (Planning Assistant - Health)

GUIDANCE OF HANDICAPPED REPORT AND RECOMMENDATIONS

Mr. A.A. Boucher (Division Chairman)

Mrs. Rhona Lucas (Planning Associate - Rehabilitation)

WELFARE OF THE AGED RECOMMENDATIONS

Mrs. M.H. Ginsberg (Committee Vice-Chairman)

Mrs. Kae McKenzie (Planning Associate - Aging)

WELFARE AND RECREATION REPORT AND RECOMMENDATIONS

Mrs. R.F.Bruce Taylor (Council Chairman)

Mr.B.A.Robinson (Planning Associate - Welfare and Recreation)

Mr. R.C. Nann (Planning Assistant - Welfare and Recreation)

I welcome the fact that these people are here, because they have done so much to help this submission and if there are any questions I am well supported with facts.

You have had in your possession for some time copies of our brief and considerable reference material which we have submitted as appendices. It is my intention, therefore, to confine myself to a few introductory remarks and to refer to a few of the highlights of our submission.

I would like to introduce my colleagues and explain to you their position on our delegation.

GENERAL REPORT and RECOMMENDATIONS

Mrs. C.W. McIlish (Committee Chairman)

Miss Amy Leigh (Consultant)

Mr. E.D. Hill (Director of Planning)

HEALTH DIVISION: COMFORT AND RECOMMENDATIONS

Dr. M.C. Doyle (Planning Associate - Health)

Miss C.W. Perkins (Planning Assistant - Health)

GUIDANCE OF HANDICAPPED PERSONS AND REHABILITATION

Mr. A.A. Brenner (Division Chairman)

Mrs. Rhona Lucas (Planning Associate - Rehabilitation)

WELFARE OF THE AGED AND REHABILITATION

Mrs. M.H. Glassing (Committee Vice-Chairman)

Mrs. Kae Helmrate (Planning Associate - Aging)

Mr. B.A. Robinson (Planning Associate - Welfare and Recreation)

Mr. R.C. Ham (Planning Assistant - Welfare and

I welcome the fact that these people are here, because they have done so much to help this subcommittee and if there are any questions I am well supported with facts.

We have had in your possession for some time copies of our brief and considerable reference material which we have submitted as appendices. It is my intention, therefore, to confine myself to a few introductory remarks and to refer to a few of the highlights of our submission.

As you are no doubt aware, the purpose of the community organization for health and welfare planning is to create an increasingly better balance between needs and resources. Community Chest and Welfare Councils are the voluntary agencies through which nearly 500 Canadian communities attempt to bring about this better balance. The Community Chest and Councils of Greater Vancouver combine the functions of both Chest and Councils in the one organization; this is not statutory, it is derived from the continuing support of the community. The agencies in the field of health are mainly directed towards sociological aspects of health and disease and it joins with other forms of community organizations in planning designed to improve the whole life of the community.

In our submission when we use the word "Health" we accept the World Health Organization definition that health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity. The Community Chest and Councils addresses itself to the Royal Commission on Health Services as a group of community minded citizens concerned with the well-being of fellow men.

Our submission, as you may have noted, consists of a general section and three special sections prepared by individual committees of the Community Chest and the Councils of Greater Vancouver and an additional section prepared by the Secretary for the Health League. As I mentioned, there are a number of appendices, a number of which contain among other things, important and informative reports and it is my hope that with your permission I can

is to create an increasingly better balance between needs and resources. Community Chest and Welfare Councils are the voluntary agencies through which nearly 500 Greater Vancouver communities attempt to bring about this better balance.

The Community Chest and Councils of Greater Vancouver combine the functions of both Chest and Councils in one organization; this is not a history, it is derived from the continuing support of the community. The agencies in the field of health are making direct towards preventive medicine and it joins with other forms of community organizations in planning designed to improve the whole life of the community.

In conclusion when we see the word "Health" we accept the World Health Organization definition that health is a state of complete physical, mental and social well-being and not merely absence of disease or infirmity. The Community Chest and Councils addresses itself to the broad definition and as its services to a group of community minded citizens concerned with the well-being of fellow man.

Our recommendations, as you may see noted, consists of a general section and three specific sections prepared by individual committees of the Community Chest and the Councils of Greater Vancouver and an additional section prepared by the Secretary for the Health League.

As I mentioned, there are a number of appendices, a number of which contain many other things. Important and informative reports and it is my hope that with your permission I can

refer very briefly to our general submission and the separate sections prepared by the specialist agencies.

In the general section of our brief we have three recommendations and the first, I think, is the most important. I think this underlines the whole problem as we see it. A coordinating health agency should be established at the national level whose basic functions would be to collect, collate and distribute relevant information to appropriate agencies; to study and assess national issues in health and the appropriateness and relative significance of various services being provided; to consider the appropriateness of the divisions of responsibility between Government and voluntary services; to devise, direct and supervise efforts to obtain needed information in specific areas which would have the widest applicability to the national community and stimulate similar efforts of individual communities; and to promote coordination and appropriate integration of services.

In our opinion the need for such a coordinated agency is of great importance, great urgency.

Our second point is that national conferences are a valuable means of increasing knowledge, stimulating interest and developing services. One of the great effects derived from such conferences comes from the vast amount of work and study done at the local level. There has never been a Canadian Conference of Health and the interest aroused by the hearings here of your Commission and the work done and preparation for that may be effectively utilized as preparation for a national conference which would, among other things, study the findings of this

separate sections prepared by the specialist agencies.

In the general section of our brief we have three recommendations and the first, I think, is the most important. I think this summarizes the whole problem as we see it. A coordinating health agency should be established at the national level whose basic function would be to collect, collate and disseminate relevant information to appropriate agencies, to study, to assess national issues in her on and the appropriateness and relative significance of various services being provided; to consider the appropriateness or the divisions of responsibility between Government and voluntary agencies; to devise, direct and supervise efforts to obtain needed information in specific areas which would have the widest applicability to the national community and thus to make similar efforts of individual communities; and to promote coordination and appropriate investigation of services.

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Commission. That seems appropriate because of the time needed for preparation. Such a conference as this might well be part of the centennial program for 1967.

Our third point arose because the Community Chest and Councils have become concerened about the number of separate health agencies which have been organized which provide assistance, provide medical, diagnosis, treatment and rehabilitation to persons suffering from specific diseased entities. Each agency wishes to provide the best of facilities and personnel and, therefore, requires specialized professional diagnostic and treatment staff; extensive clinical plant; separate administrative and clerical staff including public relations, field organizing and fund-raising personnel. This type of organization naturally entails very heavy costs which in turn leads to an ever-growing burden on public and voluntary funds. A partial remedy to some of these problems might be a central diagnostic and treatment facility shared by groups of agencies working in closely related fields. It appears logical that Government assistance should be directed to encouraging the development of central facilities which could be established to provide high-quality services to all patients suffering from allied diseases and disabilities.

It is the present policy of the Board of Directors of Community Chest and Councils to foster this type of development through its local planning organization. However, Governments at various levels play a very important role in this situation, since they provide grants to voluntary health agencies at local, provincial

needed for preparation. Such a conference as this might well be part of the sacramental program for 1 9?.

Our third point arose because the Community Chest and Councils have become concerned about the number of separate health agencies which have been organized which provide assistance, provide medical, diagnosis, treatment and rehabilitation to persons suffering from specific diseased entities. Each agency wishes to provide the best of facilities and personnel and, therefore, requires specialized professional diagnostic and treatment and clerical staff including public relations, field organizing and fund-raising personnel. This type of organization naturally creates very heavy costs which in turn leads to an ever-growing burden on public and voluntary funds. A partial remedy to some of these problems might be a central diagnostic and treatment facility shared by groups of agencies working in closely related fields. It appears logical that Government assistance should be directed to encouraging the development of central facilities which could be established to provide high-quality services to all patients suffering from allied diseases and dis-

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It is the present policy of the Board of Directors of Community Chest and Councils to foster this type of development through its local planning organization. However, Governments at various levels play a very important role in this direction, since they provide grants to voluntary health agencies at local, provincial

and national levels. It is, therefore, essential that the impact of existing Government granting policies upon the organization of voluntary health services be carefully assessed and directed for maximum benefit.

It is, therefore, our recommendation that policies governing health grants to voluntary agencies be assessed by the appropriate authority as to their impact on the organization of health services at the local community level, and that these policies be directed to facilitate the creation of the most effective forms of such services.

In turning to the specialized sections, I would like to note that during the past two years two health planning groups in the Vancouver area, the Health Division of the Community Chest and Councils and the Greater Vancouver Health League have moved to create a single organization to be known as the Health Council. This is an important change in health planning in our community and a brief description of the proposed Council is included in the introduction to the section prepared by the Health Division. However, because the Health Council is not yet operative, we have two sections submitted under the names of the Health Division and the Health League.

The Health Division section includes a summary of a number of projects which they have undertaken during the last five years. It includes the specialized work of the Committee for the welfare of the aged and the social planning section. They list the number of recommendations, and without minimizing the importance of any, I would like to note their first recommendation which

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The Health Division section includes a summary of a number of projects which they have undertaken during the last five years. It includes the specialized work of the Committees for the welfare of the aged and the social planning section. They also have number of recommendations, and without minimizing the importance of any, I would like to note their first recommendation which

emphasizes hospital home care services that would provide comprehensive care planned on an individual basis and which would release hospital beds. Their recommendation number 13 of this section also recommends a national conference, this time on "Aging".

In their recommendation number 15, they refer to the need for a central health planning information bureau which presumably would be one function of the co-ordinating health agency to which I have already referred. If that were established I think that likely this type of information bureau would be supplied as part of a coordinating agency. The health group, however, feels so strongly about this that if there was any delay or if there was not an agency formed, a coordinating agency, the need for such an information bureau is stressed.

The Health League in their submission have three recommendations, two of which we would like to stess, one referring to the importance of occupational health and the other to health education.

The third section was prepared by the Welfare and Recreation Council of the Community Chest. In their brief they make twelve important recommendations and again, without downgrading any of them, I would like to draw special attention to recommendations numbers 1, 4 and 8. The first stresses that in planning health services a close relationship be established and maintained with allied fields and disciplines in order to insure a concerted approach as there is growing awareness that seldom is there a problem in any one of these areas that does not eventually involve the others.

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The Health League in their submission have three recommendations, two of which we would like to stress, one referring to the importance of occupational health and the other to health education.

The third section was prepared by the Welfare and Recreation Council of the Community Chest. In their brief they make several important recommendations and again, without commenting any of them, I would like to draw special attention to recommendations number 1, 4 and 5. The first stresses that in planning for the services a close relationship be established and maintained with allied fields and disciplines in order to insure a co-ordinated approach as there is growing awareness that seldom is there a problem in any one of these areas that does not eventually involve the others.

Recommendation number 4 states that more resources be devoted to the question of prevention of mental illness; with one important approach being the improvement of and better coordination among the existing services to families and children in the fields of welfare, recreation and mental health.

Number 8 pleads that every effort be made to ensure appropriate granting of social assistance in amounts which permit at least minimum adequacy in shelter, nutrition, clothing, and other basic necessities, for maintaining a good physical and mental health.

The final section of our brief was prepared by the Guidance of Handicapped Division of the Community Chest and Councils, Greater Vancouver Area, and again covers a number of issues and makes twenty individual recommendations.

Since the writing of this material Bill number C-84 has now been enacted into law. However, we would like to stress that in the implementation of this legislation every encouragement possible should be given to the expansion of present vocational training services in the community. In addition to these vocational services, assessment, adjustment and training facilities should be established. This should include a program for home-bound handicapped persons.

Mr. Chairman, we are grateful to you for the courtesy of receiving us. As I mentioned before we have a number of people here who are competent to enlarge on our submission should members of the Commission have specific questions.

more resources be devoted to the question of prevention of mental illness; with one important purpose being the improvement of and better coordination among the existing services to families and children in the fields of welfare recreation and mental health.

Number 3 pleads that every effort be made to ensure appropriate granting of social assistance in amounts which permit at least minimum adequacy in shelter, nutrition, clothing, and other basic necessities for maintaining a good physical and mental health.

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Since the writing of this material Bill number 0-64 has now been enacted into law. However, we would like to stress that in the implementation of this legislation every encouragement possible should be given to the expansion of present vocational training services in the community. In addition to these vocational services assessment, adjustment and training facilities should be established. This should include a program for home-bound

Mr. Chairman, we are grateful to you for the courtesy of receiving us. As I mentioned before we have a number of people here who are competent to enlarge on our submission should members of the Commission have specific questions.

THE CHAIRMAN: Thank you, Mr. Beaupre. It is very evident from a reading of the brief submitted that a great deal of care and preparation and a good deal of time was expended in the preparation of the document and all its special sections. The fact that it is so comprehensive perhaps makes it less necessary than otherwise to follow the matter with more numerous questions. However, we welcome your organization here this morning and particularly the broad representation of those who are here with you and the information they can afford in the way of getting viewpoints from a very large section of the community. As you know, we are interested in getting views from all segments of the community and the Community Chest Organizations, the people who are interested in it, are naturally more closely connected with the consumer group as I imagine you may call them, than perhaps any other group that we can speak to. That was why in December I wrote Mr. Naphtali particularly about one or two aspects of the problems that we were particularly concerned with, and that letter referred to the problem of the medically indigent person, problems which the medically indigent persons face in obtaining medical care and hospital services in the Vancouver area in the Province of British Columbia. I know you have dealt with the subject and I am grateful for the response to that but I was wondering if you would like to develop it outside of the brief, in a sense, and we would be very glad to hear from you as to that question.

MR. BEAUPRE: Mr. Chairman, we recognize you asked the question and it is a very good question, because it is a very difficult question. We have done some

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MR. MAHRER: Mr. Chairman, we recognize you asked the question and it is a very good question, because it is a very difficult question. We have done some

work on the subjects and a number of people may like to comment on it. I would like to ask Miss Leigh if she would speak to that in the first instance.

MISS LEIGH: This matter of the medical indigent is a serious one, we believe, but it is difficult and almost impossible to tell you how the people are affected. This problem has many facets, it is not entirely one group and we have found through the years and in our recent studies that in spite of the recent developments of better services being made available there are still many who fall between the two. It seems to us that it is dangerous to set any limit on income because illness is no respecter of persons and none of us know who is going to be affected and how seriously. The group or two that I might mention are those who come between, shall I say, the independent poor and the independent rich. It does not alway depend, even so, on income, because we have seen life-savings disappear very quickly because of medications, drugs, and the high cost of treatment. There are instances where women, for instance, are ill and cannot take treatment even though it is available because there is no one to look after the children. There are still many people who have had reasonably good health through the years and do not have their own physician or doctor. We know that the medical man in this community, and I am sure in most, do give freely of their services but there is still too many people who do not have a doctor to go to. Even if the situation is diagnosed they do not necessarily have the money to pay the cost of treatments. There are many others who we might mention, some even on M.S.A. who cannot afford

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operators cannot do so. You, therefore, may need a publicly supported program, and if you need a publicly supported program for the Province of British Columbia, the question of how it should be organized and financed is of paramount importance.

If it will be agreeable to you and your associates to consider the question of what is involved, how it would be administered, what amounts would be involved over a period of five or ten years, this would be helpful to this Commission. May we ask you to do so?

MR. BEAUPRE: We would certainly do that.

MRS. GINSBERG: How do you think these things can be done by volunteers on such a level, without conference, without all these things we have stated in the brief? They are so important. Attention has been called to the home-maker service. This would have to be Government subsidized, and also the provision of home-maker services going into the home.

I would like to call to your attention and to the attention of the Commission the great amount of rehabilitation that could come from this: The care of the aged, to get them out of the institution; the help this would give us on this other vast problem of having insufficient place for our oldsters. If they have this care coming into the home, this one little facet alone is of great importance in this overall picture. In this brief you will see that our Division and Agency is also asking for a national conference on aging. We feel it is almost impossible to deal with this on a Provincial level, that

operators cannot do so. You, therefore, may need a publicly supported program, and if you need a publicly supported program, [illegible] of how it should be organized and financed is of paramount importance.

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MR. DEAUPRE: We would certainly do that.

MRS. GIBSON: How do you think these things can be done by volunteers on such a level, without conference, without all these things we have named in the brief? They are so important. Attention has been called to the home-maker service. This would have to be determined, subsidized, and also the provision of home-maker services going into the home.

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the drugs prescribed. It has many facets and it is difficult to just speak of any one who may be affected in this way.

THE CHAIRMAN: Thank you very much for that. That states the problem very clearly and concisely. Our next consideration is where we go from there. Is there a remedy? Is there some approach by which people who fit in this gap may be reached, a, by a program, one type of program that has been recommended, namely voluntary program for those who can pay for services be allowed to pay and those who cannot pay should have the services provided for them. Is there a way of finding a method of taking care of those who fall in the in between space in that type of program? Have you any comment on that?

MR. BEAUPRE: I don't believe we have. I think the reason is this, I don't think that any one can with any sense of responsibility recommend an approach unless you have some concept as to what it will entail in facilities, personnel, money. I think the extent of the study we have made so far indicates we don't know enough about it. We just don't have the dimensions of the kind of people and the kind of circumstances we are seeking.

THE CHAIRMAN: I think perhaps we can say it is established that there is such a group, it is the dimension that is not defined.

MR. BEAUPRE: Can you propose a solution when you don't know what are the dimensions of the problem. I think that has been the position we have taken. As you go through all this material it seems to me there is no lack of a number of people that are prepared to try and alleviate

[illegible] to just speak of any one who may be affected in

THE CHAIRMAN: Thank you very much for that. That traces the problem very clearly and concisely. Our next consideration is where we go from here. In the [illegible] in this map may be reckoned, by a [illegible], one type of program that has been recommended, namely voluntary program for those who can pay for services be allowed to pay and those who cannot pay should have the services provided for them. Is there a way of finding a method of taking care of those who fall in the in between space in that type of program? Have you any comment on that?

Mr. [illegible]: I don't believe we have. I think the reason is that I don't think that any one can with any sense of responsibility recommend an approach unless you have some concept as to where it will consist in facilities, personnel, money. I think the extent of the study we have done so far indicates we don't know enough about it. We just don't have the information of the kind of people and the kind of circumstances we are dealing.

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I think that has been the position we have taken. As you say [illegible] all this material it seems to me there is no lack of a number of people that are prepared to try and [illegible]

the suffering of the community. It also seems to me with the best will in the world some of the people are inefficient because there is a lack of basic data as to what the problem is. I think this is one of the fundamental bases for the proposal of a national coordinated agency, so we could more clearly spell out and define the problems we are trying to attack, so we could do it on a more realistic approach. All I can say is we don't know the answer to your question.

THE CHAIRMAN: Have you any special problem in that connection, in connection with that group, because you are a large metropolitan seaport city.

MISS LEIGH: Do you mean peculiar to us?

THE CHAIRMAN: In your situation as one of the major cities in Canada, one of the four or five?

MRS. MELLISH: I think that would be a question that would have to be directed to the out-patient department of our hospitals and the places where these people come up for attention every day. The Community Chest in studies of this kind, and one of the reasons that we were so insistent on this upper level basis was that in studies that can be made, our opportunities to make studies can only go so far. We don't have, as a voluntary group, we don't have the authority to ask for certain documents or things of this kind. We can only go so far and continually when we make studies we haven't -- we go this far. We can't go far enough to reach a solution for it. There must be that higher authority with more scope for collecting information and so on.

THE CHAIRMAN: We had a very fine document from Dr. Ranta of the Vancouver General Hospital.

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THE CHAIRMAN: We had a very fine document from Dr. Ramon of the Vancouver General Hospital.

MRS. MELLISH: Yes.

THE CHAIRMAN: Dealing with many phases of this problem. What we are wondering is in the experience of those of your table this morning, in connection with the mobility of population in a seaport city like Vancouver, are there some special problems we wouldn't meet in a city like Winnipeg which is an inland city?

MRS. MELLISH: Dr. Boyce, have you a comment?

DR. BOYCE: I don't know whether it is too enlightening, but I have one or two comments. I think the fact the British Columbia economy is based to a large extent on forestry and fishing through widely separated small communities it results in -- the simple fact Vancouver tends to be the centre of the Province results in people spending money in a way they might not do in a town such as St. Catherine's in Ontario. I think that is the only comment I can make on that as far peculiarities of British Columbia are concerned. I would like to make another comment about this problem of medical indigents. That is it seems to me that the chief reason that this is so difficult to define is that in the long run you are talking about a person's way of life, and any democracy, if you want to answer your question you have to say we will lay down a certain set of rules and find out what these rules do. I think I can illustrate my point: Take a narcotic addict who perhaps pays $100.00 a day for narcotics and at the same time is a medically indigent person who develops another illness. It is hard for me to see how you can lay down any definition that would be meaninful as far as medical indigents are concerned unless you are

What we are wondering is in the experience of those of you who have spoken this morning, in connection with [illegible] like Winnipeg which is an inland city?

MRS. KEELING: Dr. Joyce, have you a [illegible]

DR. JOYCE: I don't know whether it is too enlightening, but I have one or two comments. I think the fact the British Columbia economy is based to a large extent on forestry and fishing through widely dispersed small communities it seems in -- the single face Vancouver tends to be the centre of the Province results in people spending money in a way they might not do in a town such as St. Catherine's in Ontario. I think that is the only [illegible]

Columbia are concerned. I would like to make another comment about this problem of medical indigence. That is it to define is that in the long run you are talking about a person's way of life, and any democracy, if you want to answer your question you have to say we will lay down a certain set of rules and find out what those rules do. I think I can illustrate my point: There a narcotic addict the person pays $100.00 a day for narcotics and at one time is a medically indigent person who develops another illness. It is hard for me to see how you can lay down any definition that could be meaningful as far as medical indigents are concerned unless you are

prepared to describe what kind of life this individual should lead. In other words, how much should he have for his medical bills, how much should he spend on television, etcetera, etcetera.

THE CHAIRMAN: Does this sort of inevitably lead us not to a voluntary scheme but a compulsory one?

MISS LEIGH: Mr. Chairman, it would seem to me and my associates that this is the only way it would really be completely covered because it is true a person could be quite independent today and medically indigent tomorrow, not through any fault of his own. These are some of the difficulties that is found in describing them. If we try to define this and go through the community to find out who is indigent, then we run into the tremendous cost of the means test. That is really what it would amount to, which is tremendously costly and also added to that is the individual decision of the person administrating that as to what is right and what is wrong and how much he should spend on this and that. It seems to me as long as this problem continues there will be more and more sick who cannot afford the money, who are not getting medical coverage, even if in some instances it is their own fault. And I am sure there are a few.

MRS. MELLISH: In thinking this through, sometimes when you are dealing with a problem on a large scale it will help to look at it on a small scale and see what happens there. I am thinking now of a large company in British Columbia. The employees of this company considered by and large with the high cost of illness they were

prepared to decide what kind of life one's individual should lead. In other words, how much should we have for [illegible]

THE CHAIRMAN: Does this part of [illegible]

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MRS. MERLISH: In thinking this through sometimes when you are dealing with a problem on a large scale it will help to look at it on a small scale and see what happens there. I am thinking now of a large company in British Columbia. The employees of this company considered by and large with the high cost of illness they were

all medically indigent irrespective of their salaries. They got together and set up their own medical school and each employee paid a certain amount in every month and now there are none of them medically indigent. I think that is the kind of thing you have to do in the country if you are going to eliminate medical indigency. How it would be brought about on a country-wide basis instead of a company-wide basis I wouldn't be able to say.

MRS. GINSBERG: Speaking on behalf of the Division of Aging Individuals in British Columbia there are more aging in view of the wonderful climate. I appear on behalf of the Board of Commerce to tell you it is the most beautiful province in Canada. They are coming here from all places. Our problem is much more vital because of the reasons of numbers. We are not dealing with it in an adequate way. We are doing the best we can. We don't know. We don't know the numbers. We know they are not getting the medical health treatment they require. There is much to be done to awaken public interest. As far as B.C. is concerned we do know we have more numbers here in the older age group.

THE CHAIRMAN: Mr. Beaupre, in referring to your recommendation number 3, this Commission has set up a study, we have commissioned a study on the subject of the health grants and the various implications, and that is one of the studies, a particular direction has been given and on which we will have factual and assessed judgment of the people who are doing the study themselves.

MR. BEAUPRE: We welcome that study very much, sir.

all medically indigent irrespective of their salaries. They got together and set up their own medical school and each employee paid a certain amount in every month and now there are none of them medically indigent. I think that is the kind of thing you have to do in the country if you are going to eliminate medical indigency. How it would be brought about on a country-wide basis instead of a company-wide basis I wouldn't be able to say.

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[illegible]

[illegible] to your recommendation number 3, that Commission has set up a [illegible], we have commenced a study on the subject of [illegible]

MR. BRADFIELD: We welcome that study very much, sir.

COMMISSIONER FIRESTONE: Mr. Beaupre: I would like to congratulate you and your associates on this very comprehensive submission and your large number of recommendations. They are very helpful to a Commission that is trying to deal with a problem and come up with some answers. It is people like yourselves who can help us in developing these answers. May I direct my question to some of the recommendations that have been made so we will have a more specific understanding. Please feel free to refer any of the questions to any of the experts you have in your illustrious gathering.

I would like to follow up the point the Chairman just made and refer to your recommendation 3 on page 3 of your general text. You say in paragraph 3: "That policies governing health grants to voluntary agencies be assessed by the appropriate authority as to their impact on the organization of health services at the local community level and that these policies be directed to facilitate the creation of the most effective forms of such services." Mr. Beaupre, have you or your associates any specific proposals to make as to how the existing system of health grants as far as it concerns voluntary agencies could be improved?

MRS. MELLISH: Mr. Chairman, when the Committee was working on this brief it was the first consideration that the financial aspect would be part and parcel of this coordinated health agency. Then it was recognized that the kind of health agency we were envisaging, they would have no responsibility whatsoever for financing. It was felt that the original coordinating group, the findings

recommendations. They are very helpful to a Commission that is trying to deal with a problem and come up with some answers. It is people like yourselves who can help us in developing these answers. May I direct my question to some of the recommendations that have been made so we will have a more specific understanding. Please feel free to refer any of the questions to any of the experts you have in your illuminous gathering.

I would like to follow up the point the Chairman just made and refer to your recommendation 3 on page 3 of your general text. You say in paragraph 2: "What policies governing health grants to voluntary agencies be assessed by the appropriate authority as to their impact on the organization of health services at the local community level and that these policies be directed to facilitate the creation of the more effective forms of such services."

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MRS. MEDLIN: Mr. Chairman, when the Commission was working on this brief it was the first consideration that the financial support would be part and parcel of this coordinated health agency. Then it was recognized that the kind of health agency we were envisaging, they would have no responsibility whatsoever for financing. It was felt that the original coordinating group, the findings

of that group would be used at times when applications were made to any level of Government for grants towards health agencies.

COMMISSIONER FIRESTONE: Do you feel that the existing system is inadequate?

MRS. MELLISH: No, I don't want it to be thought we are in any way criticizing what has been done.

COMMISSIONER FIRESTONE: You are not necessarily criticizing. You are explaining to us how this system works, how it could be improved. We don't take it as criticism, but as a helpful solution.

MRS. MELLISH: Over the past what has happened in the voluntary health agencies, it was inevitable and good at the time, a group of people would become concerned about a particular problem, they would get together to do something about it, and they would apply for a grant, for a health grant. It might be that they would only want Provincial money or they might want both Provincial and Federal money and their application would forward and would be considered in an isolated situation, and they would raise the money or not as it was felt at that time. We feel that these should not be considered in isolation, that they should be considered as part of a plan. I do know when application comes forward for Federal health grants it has to be accompanied by -- to the Province that it is within part of the Provincial health plan. I don't think it goes far enough. What I -- we don't think it goes far enough. We think there should be more coordination and cooperation at this level between these agencies. They

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should not be considered in isolation, although at times in the past I may admit I have been very glad that they were.

COMMISSIONER McCUTCHEON: You mean you had some health grants?

MRS. MELLISH: That is correct.

COMMISSIONER FIRESTONE: Do I understand you might have had difficulties in particular requests for health grants that have been passed on to the Provincial Government but which the Provincial Government might have refused to pass forward to Ottawa?

MRS. MELLISH: That isn't the point we are making. The point we are making is if a grant, if the request comes forward for grants for a particular health agency, that the grant should -- that the work that the agency is doing should be looked at in relation to what is being done in the field, what others are doing. How can this money be used to the best advantage if this money was granted in a different way, would it achieve the same purpose, perhaps more effectively. In fact, what we are saying is that the time is now, when we have to make better use of everything that we have got, our personnel, our facilities and our financing. That can only be done on a comprehensive plan, not a hit and miss and piecemeal.

COMMISSIONER FIRESTONE: We appreciate the integrated approach you are recommending. I think it makes a lot of sense. What we are trying to establish is what some of the problems and difficulties are you have encountered. In order to improve on an existing scheme one must appreciate the difficulties or the problems, if you have no problems and no difficulties you may say that

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Mrs. MELLISH: That is correct.

stand you might have had difficulties in particular requests for health grants that have been passed on to the provincial

refused to pass forward to Ottawa?

Mrs. MELLISH: That isn't the point we are making. The point we are making is if a grant, if the request comes forward for grants for a particular health agency, that the grant should -- that the work that the agency is doing should be looked at in relation to what is being done in the field, what others are doing. How can this money be used to the best advantage if this money was

past, perhaps more effectively. In fact, what we are saying is that the time is now, when we have to make better use of everything that we have got, our personnel, our facilities and our financing. That can only be done on a comprehensive plan, not a hit and miss approach.

COMMISSIONER MURSTONE: We appreciate the integrated approach you are recommending. I think it

one must appreciate the difficulties or the problems, if you have no problems and no difficulties you may say that

is the case.

MR. BEAUPRE: I don't think that is the point we are talking to at all. I don't think we have tried to come with suggestions that health grants are difficult or easy to secure. All we are suggesting is that like everything else there is not enough money to go around. In some instances we are saying they are granted too generously or too indiscriminately. With whatever money is available more consideration should be given to the overall concept and less decisions made on the basis of individual applications.

COMMISSIONER FIRESTONE: Mr. Beaupre, you are quite right in saying you haven't answered my question. What you are saying you want an integrated plan. I think this is a very laudable objective. This Commission is concerned in making recommendations to a Government. We must base these recommendations on certain specific problems or on specific principles or specific difficulties if such have occurred we would be happy to hear about them. If you haven't had any problems or difficulties all you have to do is say you haven't and therefore we will come to the next exhibit.

MR. BEAUPRE: As the Community Chest, of course, we are not eligible for these. Obviously our member agencies are. Perhaps Mr. Naphtali would answer.

MR. NAPHTALI: Our main problem stems from the increasing numbers of developing agencies in allied dieseases. Let us take for an example the neuro-muscular area. Here is an area we feel needs exploration. All we are saying really is that the growing policies, having

MR. BEAUPRE: I don't think there is the point we are talking to at all. I don't think we have tried to come with suggestions that health grants are difficult or easy to secure. All we are suggesting is that like everything else there is not enough money to go around. In some instances we are saying they are granted too generously or too indiscriminately. With whatever money is available more consideration should be given to the overall concept and less decisions made on the basis of individual applications.

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encouraged this kind of development they must be directed to an analysis in terms of how better coordinated these agencies may be.

How they can use facilities; how we can make more use of the money that there is. Certainly, in the voluntary field, there are limits on money, and I am sure the same thing must apply to Government.

COMMISSIONER FIRESTONE: Thank you very much.

If I may, now, come to recommendation VII in the section entitled Report Prepared by the Health Division of the Community and Councils of Greater Vancouver Area.

If I understand you correctly, you say this was an important recommendation which you emphasized, and I quote:

"That a continuing program be carried out on a national level designed to make health planning in all areas of Canada more effective and more economical by constant study and evaluation of the health status of the population, with special reference to the incidence and prevalence of chronic conditions".

I wonder whether you or any associate you may wish to designate could explain to us how in practice such a national planning effort in the field of health would be carried out, and what the means of cooperation would be between people at the national level and the regional and local levels?

MR. BEAUPRE: Mr. Henderson is Chairman

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MR. MEAUPRE: Mr. Henderson is Chairman

of the Health Division, and he may like to comment on that.

MR. HENDERSON: This particular subject, Mr. Chairman, arises out of a study that was done in this area, and as a matter of fact it was done by the research director, Mr. Blishen, who is on the Commission. He has gone in very thoroughly to a number of areas of lack of information, and this is basically our point, that we must have concrete information and necessary information before some of the plans can go forward. I think this ties in with a great number of the other points we have been raising, sir.

COMMISSIONER FIRESTONE: What I would like to understand is how you could, assuming that this type of work that you have recommended is being carried out at the national level, say, in the Department of National Health and Welfare or any other agency designated, and this information would help to make "health planning in all areas of Canada more effective", how do you visualize that information collected at the national level would make planning at the regional or local level more effective?

MR. HENDERSON: I think the basis of this is that the collection of information at the national level would be from area statistics that are collected and they would then come back to the local areas showing how big a problem is in a certain specific disease, say. That is how we have visualized using this type of information.

COMMISSIONER FIRESTONE: Let us say the information comes now back to a regional level, where would it go to? And who would do something about it? We are

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COMMISSIONER FIRESTONE: Let us say the information comes back to a regional level, where would it go to? And who would do something about it? We are

just trying to visualize the practability of the proposal.

MR. HENDERSON: I think, sir, the information would come back to, in our case, we would feel it should come back to the community. It would then be passed to the Health Council who then would pass that out to the specific group that are concerned with the disease in question. Was that the approach you were speaking of?

COMMISSIONER FIRESTONE: I am wondering how you would use this information for recommendations to the Government planning agencies and agencies collecting information. This all costs money, and unless we can say what purpose this will serve, it would be difficult for this Commission to make such a recommendation. How do you plan to support how you will use it?

MR. BEAUPRE: I think that fundamentally if we repeat to you the statement made earlier, that we had two health planning groups in Vancouver. These are being merged into the Health Council now. We attach a great deal of importance to what they will do. This really will be the centralized area that will help with the plan, not only all the agencies in the Chest, but other people operating in the field. I think it is inevitable that the work followed will depend on the information at hand. As Mrs. Mellish said before, in agencies such as ours, it is difficult to secure it.

Your specific request as to who would use it, I would say I think it would be specifically the Health Council at the greater metropolitan area.

DR. BOYCE: First of all, Mr. Chairman,

be passed to the Health Council who then would pass that out to the specific group that are concerned with the disease in question. Was that the approach you were [illegible]

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if I may, I would like to refer to Mr. Blishen's study. He stressed the fact that he did his best to stress the fact that this was the sociological aspect of health and not health. The second point -- for anyone who has read his report carefully, I am sure that they could not help but draw the conclusion that he is constantly referring to areas in which we have no information whatsoever.

I might illustrate this point by saying one can count up the cases of cancer or the number of cases that report, but you have no idea of the number of people who may have it, or have not been seen or collected in statistics one way or another. I think the question regarding recommendation VII might be combined with recommendations XV and XVI, that at least, from my point of view, it makes more sense to refer to the national centre for health statistics.

No doubt some members of the panel have seen the kind of reports that come out of this from the United States Department, which are very generous in providing them to us, and I know that within the last three months there has been information that is of great use to Canada. I suggest, sir, that it is conceivable that if the Federal Government plan a similar organization for similar reasons that it is quite possible that we could add our information to theirs and visa-versa, and this would be a most efficient operation on the continent of North America.

Does that answer your question?

COMMISSIONER FIRESTONE: Well, it is very helpful, sir.

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COMMISSIONER BIRSTOWE: Well, it is very helpful, sir.

Let us assume that the Federal Government accepts that recommendation, and a comprehensive program of collecting health statistics is developed, and then those health statistics are made available to the British Columbia region.

How are those health statistics going to be used by your own Division for planning purposes? We have to justify expenditures of the tax-payers' money, and unless we can convince the Government this information will be used practically and usefully, it is very difficult to make such recommendations. Can you tell us how you would use it for both regional and local planning purposes?

DR. BOYCE: I think, again, that the Commission has received, right across the country, recommendations that a hospital home care program or a homemaker service be established. We have just completed a report which tries to lay down what such a service should be, and what the needs are, and how these might be met, as specifically as we can. But, invariably, we are faced with the problem of an extremely expensive survey to get the kind of data that one could plan specifically on, and without this data, I think when one approaches a Government, they are pretty careful as to how they give out the money, and they will not give it out on the basis of opinion, but only on the basis of fact.

I would say, sir, that any responsible planning organization would be aware of a single centre for information, and that I would add that in return for the information they get, which would be so helpful in logical and realistic planning, they in turn would supply

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their information to the Health Information Centre; that this would be, if you like, a basic technique in planning.

COMMISSIONER FIRESTONE: It would be a two-way flow?

DR. BOYCE: That is right.

COMMISSIONER FIRESTONE: The basic statistical information would come to the regional centres, they would do the analysis, and then the end results would flow back?

DR. BOYCE: That is right. The reports would automatically be sent to Ottawa. I think it is fairly obvious why we are saying that this sort of scheme is not something that could be established either on a municipal or provincial basis. It involves the whole of Canada for accurate planning.

COMMISSIONER FIRESTONE: In other words, what you are saying, if I understand you correctly, is that the additional health data acquired is essential to health planning on a national, regional and local basis?

DR. BOYCE: That is right.

COMMISSIONER FIRESTONE: And you so recommend?

DR. BOYCE: That is right.

MR. BEAUPRE: You mention this two-way flow. I would suggest that the flow to Ottawa should not be a filing cabinet service only. We feel that if any information came in on work done here in Vancouver, then it should be made available to other communities. What now happens is when we start on a program, to study aging problems, for example, or something like that, we do not know

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DR. BOYCE: That is right.

COMMISSIONER FRASTON: And you so recommend?

DR. BOYCE: I do indeed.

MR. BRAUPER: You mention this two-way flow. I would suggest that the flow to Ottawa should not be a filing cabinet service only. We feel that if any information came in on work done here in Vancouver, then it should be made available to other communities. What now happens is when we start on a program, to study aging problems, for example, or something like that, we do not know

if people in Halifax or St. John's are studying the same thing. We suffer in geography. In many instances, when organizations such as our own with very limited funds engage in work, we have no knowledge at all whether the same sort of thing has been done in Halifax or some other part of the country. There is no easy way of finding this out. I think we have found instances where we have engaged in studies only to find later that the same work has been done somewhere else. I think care should be taken that they should not be duplicated.

COMMISSIONER FIRESTONE: How would you achieve that?

MR. BEAUPRE: I think there should be some method of reporting. If information was available in Ottawa, it should be disseminated in much the same way that other Government's statistical information is disseminated if people want it, even if it is just a list of reports.

COMMISSIONER FIRESTONE: May I turn to one more question, and this is a recommendation in the section entitled "Report Prepared by the Greater Vancouver Health League, January, 1962". I am referring to the middle section headed "Private Hospitals, Nursing Homes and Boarding Homes". In paragraph 2 you say here:

> "That the problems of providing care to the aged and infirm below the level of the acute general hospital continue to receive the attention of both provincial and federal authorities."

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COMMISSIONER FITZGATOWN: How would you achieve that?

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COMMISSIONER FITZGATOWN: May I turn to one more quotation, and this is a recommendation in the association entitled "Report Prepared by the Greater Vancouver Health League, January, 1962". I am referring to the middle section headed 'Private Hospitals, Nursing Homes and Boarding Homes". In paragraph 2 you say here:

"That the problems of providing care to the aged and infirm below the level of the acute general hospital continue to receive the attention of both provincial and federal authorities."

Mr. Beaupre, has your organization any complete proposals of how to improve the care for the aged and infirm in the Province of British Columbia, either in terms of increasing the number of homes for the aged, home care, and additional suggestions. We are looking for concrete proposals of how this very worthwhile objective can in fact be implemented.

MR. BEAUPRE: I think Mrs. Mellish should speak to that.

MRS. MELLISH: Mr. Chairman, the situation here in British Columbia a little while ago was that below the level of the acute general hospital, the various institutions giving care to the aged and infirm were completely unlicensed other than as boarding homes, until you came to the boarding home that was giving care to welfare cases. The Welfare Institutions Act did provide for inspection and licensing of any establishment where there were two or three welfare cases, but if the resident or the patient was a paying patient, then there was no check on them at all other than the fact that they had to have a licence from the municipality to run a boarding home.

This has created, as you can imagine, some very desperate situations in which aged people or chronic cases were of necessity placed in nursing homes, boarding homes, rest homes, and whatever you may call them, and other than the restraints of their own good sense or good feeling or of a visiting physician, there was nobody who could go into that home and tell these people what they must do.

This was a great concern to everybody,

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MR. BEAUPRE: I think Mrs. Mullish should speak to that.

MRS. MULLISH: Mr. Chairman, the situation here in British Columbia a little while ago was that below the level of the active general hospital, the various institutions giving care to the aged and infirm were completely unlicensed other than as boarding homes, until you came to the boarding home that was giving care to welfare cases. The Welfare Institutions Act did provide for inspection and licensing of any establishment where there were two or three welfare cases, but if the resident or the patient was a paying patient, then there was no check on them at all other than the fact that they had to have a license from the municipality to run a boarding home.

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and the Greater Vancouver Health League had a committee studying the matter and it came out with so many details of what needed to be done that it enlisted the aid of the Department of Law out at the University and our report to the Provincial Government was drawn up in the form of an Act, a proposed Act, and you have a copy of that in your material.

As a result of the recommendations and the discussions that went forward with the Provincial Government over this, there were two changes made. There was a change made to the Welfare Institutions Act which brought under that Act all homes who were providing care to people who were other than patients. It made a change to the Private Hospitals Act, or to the Hospitals Act with a different definition of the word "patient". So that, now, in British Columbia since the session of last Spring, everybody in a home of that kind is covered by some Provincial legislation.

Now, the status of the thing at the present moment is that the new regulations under these two changes are being drawn up. They are being prepared by a joint committee of the Greater Vancouver Health League which will now be the Health Council, and the permanent officials of the Health and Welfare Departments.

We are hoping this is going to bring about -- certainly a great many improvements have already been made in that all of those places now must have a licence. They are all subject to inspection. So that is what we are hoping, that this will continue and that further improvement will be made.

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This, we see, is only the first step in this. There is still a great deal more to be done.

COMMISSIONER FIRESTONE: Are there adequate facilities for the care of the aged and infirm in the Province of British Columbia?

MRS. MELLISH: No.

COMMISSIONER FIRESTONE: It may be perhaps a very difficult thing, Mr. Beaupre, at this stage to ask you or your associates what could be done about it, because your recommendations is couched in general terms.

Would it be possible for you and your colleagues to consider the question and let us know at a later date, perhaps in writing, as to what would be a number of concrete recommendations of what could be done to cope with this problem and what contribution the Federal Government can give to such a program.

As you realize, we are trying to get ideas from people like yourselves who are familiar with the problem, and if this can be done at a later stage and made available to us in writing, it would be very helpful.

MRS. MELLISH: One of the problems, Mr. Chairman, is that a number of these homes are private enterprise; they have begun in converted dwellings. The facilities are not always as they should be. New buildings really are needed if we are to have adequate programs. The problem is how are these to be financed. That is something which is concerning the private operators themselves and our own Provincial Government at this time.

COMMISSIONER FIRESTONE: You are quite right. Perhaps the problem is so big that the private

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COMMISSIONER FIRESTONE: You are quite right. Perhaps the problem is so big that the private

this problem must be talked about nationally. If we can get together the different provinces and talk through their problems not only do we develop a broader outlook, but the public interest awakens. This happened in the case of the White House Conference of which you may be aware and this did create interest in a knowledge of what is needed for the aged, what can be planned for. This type of conference is very worthwhile.

COMMISSIONER FIRESTONE: You have made a very moving plea for a comprehensive program for the Province of British Columbia and you are very convincing. All we would like to have from you is your idea of what you consider is a desirable program that can be implemented.

COMMISSIONER VAN WART: I would gather from what you have said you do not visualize a municipally financed, poor-house scheme such as they have in England and the Atlantic Provinces for the aged?

MRS. GINSBERG: No, we are more in favour of using the scheme to provide adequate housing for our older citizens and keeping them in their own homes in the community where they belong as part of the community.

THE CHAIRMAN: Thank you very much, Mr. Beaupre and those who came here this morning. You have been extremely helpful to us and we appreciate your attendance and the work that has gone into the preparation of your submission.

We will recess now for a few minutes.

---Short Recess.

THE CHAIRMAN: If you will come to

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MRS. GIBBERD: No, we are here in favour of using the scheme to provide adequate housing for our older citizens and keeping them in their own homes in the community where they belong as part of the community.

THE CHAIRMAN: Thank you very much, Mr. Bourque and those who came here this morning. You have been extremely helpful to us and we appreciate your attendance and the work that has gone into the preparation of your submission.

We will recess now for a few minutes.

THE CHAIRMAN: If you will come to

order we will proceed with the Federated Legislative Council Elder Citizens Associations.

S U B M I S S I O N O F

FEDERATED LEGISLATIVE COUNCIL ELDER CITIZENS ASSOCIATIONS

APPEARANCES:

MR. W.C. KELLY

MR. A. CLAUDE HILL

MRS. R. GIBSON

MR. T.E. BRADLEY

MR. C.W. PULHAM

MR. G.L. INGRAM

MR. J. W. CHESTERMAN

MR. A.V. HARPER

MR. B. HARTT

MRS. R.C. SMITH

MR. J. HITCHEN

THE CHAIRMAN: Yes, Mr. Kelly?

MR. KELLY: Mr. Chairman, ladies and gentlemen:

SUMMARY

(a) We advocate an all-inclusive contributory health scheme for all Canadians.

(b) Contributions should be scaled according to the ability of people to pay.

(c) We feel that the Canadian Government should supervise and control all research into cause and cure of disease. This would cover research into cause and cure of heart disease, cancer, multiple sclerosis, arthritis.

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S U B M I S S I O N O F

MR. W.C. KELLY

MRS. R. GIBSON

MR. T.E. BRADLEY

MR. KELLY: Mr. Chairman, ladies and gentlemen:

SUMMARY

(a) We advocate an all-inclusive contributory health scheme for all Canadians.

(b) Contributions should be scaled according to the ability of people to pay.

(c) We feel that the Canadian Government should supervise and control all research into cause and cure of diseases. This would cover research into cause and cure of heart disease, cancer, multiple sclerosis, arthritis.

(d) Health education and services of Preventive Medicine should be included in Health Services.

BRIEF

The Federated Legislative Council of Elder Citizens is an association of thirteen affiliated groups of elder citizens in British Columbia. We have a council that meets twice each month with five delegates from each affiliate, to consider and make representations to the various levels of government on matters relative to the welfare of the elderly. We are all retired people living on small industrial or old-age pensions and all our efforts are voluntary and unsalaried.

We represent a large segment of the elder citizens of this province and we feel that we are expressing the sentiments of a great many such people both within and outside our organization.

People in our age group are more susceptible to illness and disease and are more in need of medical care and medication than those in younger groups. As a result of having to live on static incomes which do not increase as the cost of living advances we are decidedly penalized when sickness strikes. Some of us on low incomes can qualify for Provincial Social Assistance, but a large proportion of our elder citizens are what we term "border-line cases". They are unable to qualify for Provincial Social Assistance and yet do not have assets sufficient to render them independent of financial worries. Such people are continually concerned with cost of shelter, food and clothing, and when hospital, doctor's and drug bills accrue, these place additional anxiety and worry on

(d) Health education and services of Preventive Medicine

B R I E F

The Federated Legislative Council of Elder Citizens is an association of thirteen affiliated groups of elder citizens in British Columbia. We have a council that meets twice each month with five delegates from each affiliate, to consider and make representations to the various levels of government on matters relative to the welfare of the elderly. We are all retired people living on small industrial or old-age pensions and all our efforts are voluntary and unsalaried.

We represent a large segment of the elder citizens of this province and we feel that we are expressing the sentiments of a great many such people both within and outside our organization.

People in our age group are more susceptible to illness and disease and are more in need of medical care and medication than those in younger groups. As a result of having to live on static incomes which do not increase as the cost of living advances we are decidedly penalized when sickness strikes. Some of us on low income can qualify for Provincial Social Assistance, but a large proportion of our elder citizens are what we term "border-line cases". They are unable to qualify for Provincial Social Assistance and yet do not have assets sufficient to render them independent of financial worries. Such people are continually concerned with cost of shelter food and clothing, and when hospital, doctor's and drug bills accrue, these place additional anxiety and worry on

them. This compounding of anxiety has a serious and in some cases a disastrous effect on elderly people.

We maintain that the above indicates an urgent necessity for a complete Health Plan that would include:

(a) Hospital coverage

(b) Physician's fees

(c) Ambulance services

(d) Drugs

(e) Chiropractic and Chiropodic services and treatments

(f) Necessary therapy appliances and appurtenances

(g) Diagnostic and preventative services.

We realize that such a scheme as we advocate would be very costly and at the outset would require a substantial subsidy from government funds. In due course the plan would be self-supporting from contributions made by all people of Canada. There will no doubt be people who, because of low income, are exempted from payments. Such people as aged, infirm, handicapped and chronically ill, are even more in need of medical coverage than the able and those gainfully employed. In later stages of the scheme such people will have made their contributions during productive years. Many elderly people in the above group are in the affiliates we represent and there are many others who are alone and inarticulate. We feel that such people are entitled to inclusion in a National Health Services Scheme.

No one, these days can be unaware of the pressure put on the public to contribute to drives to

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No one, these days can be unaware of the pressure put on the public to contribute to drives to

raise funds for research and alleviation of several ailments that are in the nature of health scourges. The campaign against poliomyelitis seemed to be the most intensive and extensive and it appears to have tapered off, either because insufficient funds were raised or a satisfactory treatment was discovered. However, we still have drives for heart ailments, cancer, the arthritis and rheumatism group, multiple-sclerosis, tuberculosis, and others that are a serious menace to the health of many Canadians. It appears that a group of interested or dedicated people in each case form a society that raises funds and pays for research projects. We do not wish to minimize the work they do but we feel that the method is wrong. Such funds should come from the public purse and research projects into all ailments should be co-ordinated nationally. Competent direction and supervision should be under the close control of the nation rather that at the discretion of amateurs, however dedicated. Support from and control by Government would lend stability to research which presently is dependent each year on the effectiveness of public appeals.

For these reasons we urge that research be under the control and supervision of the Government of Canada and be included in a National Health Scheme.

We sincerely hope that you will recommend to the Government of Canada an all-inclusive contributory Health Plan and that it may be put into operation as expeditiously as possible.

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For these reasons we urge that research [illegible] Canada and be included in a National Health Scheme.

We sincerely hope that you will recommend to the Government of Canada an all-inclusive contributory Health Plan and that it may be put into operation as expeditiously as possible.

THE CHAIRMAN: Thank you, Mr. Kelly. Would you care to expand on just what you mean by an all-inclusive contributory plan? What is it you have in mind when you make that statement and use that expression?

MR. KELLY: An all-inclusive plan, I have attempted to outline it in the early part of the brief. All-inclusive in the sense that it ---

THE CHAIRMAN: It is the contributory phase I was interested in.

MR. KELLY: We conceived the idea of a plan which would be extensive throughout the country and contributed to by everyone in the same way that contributions are made to pensions or unemployment insurance or income tax. This appeared to us to be the logical method of doing it, the fact that all Canadians are covered and those gainfully employed might make a contribution of their income to such a program.

THE CHAIRMAN: Is that the same as a premium plan? Is that what you have in mind? That is, you pay so many dollars a year towards a program of health care and health services?

MR. KELLY: A little different idea; they would be contributions according to the ability to pay, there would not be a fixed amount unless you fixed a minimum. It should be a percentage of income.

THE CHAIRMAN: Have you a suggestion to make on how that type of contribution would be arrived at in relation to the ability to pay?

MR. KELLY: We conceive the idea of doing it on the same basis or perhaps tied in with income

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tax which would mean those who did not pay income tax would not make a contribution.

THE CHAIRMAN: And through that fund you would pay for all health services?

MR. KELLY: That is our idea.

COMMISSIONER FIRESTONE: Would you be in favour of a means test?

MR. KELLY: To the extent that the income tax is a means test, those who do not pay income tax are in effect submitting themselves to a means test.

COMMISSIONER FIRESTONE: But you would not be in favour of a special means test for people who demonstrated that they have very low income or they cannot pay any premium that is demanded?

MR. KELLY: There are bound to be fringes where there are people just on the edge of income tax or in claiming exemption. The means test is rather an unpleasant word in British Columbia, we do not like it and would like to avoid it if we could.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Well now, you have a number of ladies and gentlemen with you, do any of the others wish to make a statement or to expand further on your submission?

MR. BRADLEY: I think Mr. Kelly has covered it. We could go into details but it is beyond our ability to go further than that. I think we have said this concisely and clearly and we have always had faith in our Governments and they will work out a plan. I am sure they

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have all the machinery and personnel to do this and I would prefer to leave it up to our Governments to work this out.

MR. CHESTERMAN: I listened with a great deal of interest to the medical submission Tuesday and also a great deal of interest to the previous panel. My interest is chiefly concerned with the care of elderly people, people who are unable to look after themselves. We realize that a lot of those people are taking up accommodation in the hospitals and we all know there is a shortage of beds in the hospitals. We cannot accommodate everybody for any length of time. Now, my contention is that some scheme could be worked out for Government rest homes to take care of the aged who are ambulatory but need home care, that do not require hospital care but when they do require it, they could be moved to the hospital. These people want loving home care and that I think would solve a lot of the problems of the elderly people and incidentally relieve the hospital of its bed shortage.

Now, I have in mind a residence, where, we call it a residence, operated by the Independent Order of Oddfellows. These people in the residence are all ambulatory and do not require medical care but they do have a real home service, real home care. They have a matron there who is very, very favourable to elderly people. This is what I think is needed in British Columbia and in all parts of Canada, nice home care for elderly people, so they finish their days in comfort, and not be afraid they are going to be a burden on the state. That could be operated quite simply; I think in the case of the residence I

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THE CHAIRMAN: That is a very worthwhile suggestion and one that we will certainly take into consideration and have before us when we are dealing with the subject.

MR. HARPER: I think as far as I am concerned the answers already given have covered my ideas. We do hope the Government will move in this matter, because we in this Province feel that there is a terrible need for medical assistance and we do not find too much sympathy for this idea among the doctors. We feel it has got to be done outside of the medical men and we hope when it is completed they will cooperate with the plan.

COMMISSIONER VAN WART: Is it not true that elderly people are happier when they are associating with other elderly people rather than younger people?

MR. HARPER: Very much so. There are housing schemes here in Vancouver that have been brought into existence by different organizations and many of them were coming up with the idea of having so many senior citizens and so many families moving into them. Our group is against it absolutely because old people like quietness and seclusion to a certain extent and when it comes to

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mingling with children it becomes very obnoxious in many cases. We hope that will be taken care of in any scheme that is brought forward to assist the aged people.

THE CHAIRMAN: Thank you very much, Mr. Kelly, you and your group. We are grateful to you for having come forward with your submission and your representations that will have our consideration.

MR. KELLY: I expect during the days you have been here you have heard a considerable amount about elderly people. There is considerable evidence that there is a concentration of retired people in this province. I think 120,000 is the number usually quoted for the old age security pensions paid in this province.

MRS. HARTT: I was here yesterday, but I didn't hear anyone stress the necessity for chiropodic care. So many of the older people are having so much foot trouble I think it is very essential that something be done in that line for older people particularly.

THE CHAIRMAN: We are going to have this submission from the Podiatrists, from the British Columbia Association of Chiropodists tomorrow.

MR. PULHAM: Mr. Chairman, we represent, all of us represented in this group, senior citizens, old age pensioners, in fact most of us are over 70 years of age. We may look younger, but we are not. We are doing our very best to do what we can to bring to other people the like age in this province some help and relief in every way possible. You will notice in the bottom of page 1: People in our age group are more susceptible to illness and disease and are more in need of medical care and medication

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than those in younger groups. It is true, and it is why we are here; this is why we prepared this brief in the short form, because we don't want to take up your time. You have many, many groups across the country, received many briefs, but I wanted to mention the one fact, that we are representing as our President, Mr. Kelly said 125,000 people in the Province of British Columbia. These are people we want to see have some help. Those people cannot all pay doctor's bills. They may be a few, but very, very few. Many are borderline cases and those are the ones who we are trying to get some assistance for and why we advocate a medical health scheme such as outlined.

THE CHAIRMAN: Thank you. The idea of having an organization such as you to represent the elderly citizens is a great thing and we are grateful to you for having come before us and for having made a submission.

MR. INGRAM: Mr. Chairman, you must realize we are the people of our age group who have better health and we wish to help our colleagues. One thing, we run into chronic hospitals, nursing homes all which need funds. There would be a considerable amount of money put into private nursing homes, private hospitals or nursing homes or nursing attention and chronic hospitals are also a feature required because some of us never get well. We all realize that. You are well posted on these factors. In addition to us representing the elder citizens we do strive to alleviate our burdens in other ways, by approaching firms for various concessions. We are looking in every corner to find out what we can do to relieve the strain on some of our members. The public denturists give us a

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THE CHAIRMAN: We are going to get old, that is for sure.

MR. KELLY: You can't avoid it.

THE CHAIRMAN: Thank you very much.

MR. KELLY: Thank you, sir.

THE CHAIRMAN: We will now hear from the Narcotic Addiction Foundation of British Columbia.

THE SECRETARY: That will be Exhibit 177, sir.

---EXHIBIT NO. 177: Submission of the Narcotic Addiction Foundation of British Columbia.

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SUBMISSION OF

THE NARCOTIC ADDICTION FOUNDATION OF BRITISH COLUMBIA

APPEARANCES:

DR. L. R. RANTA

MR. S. McMORRAN

DR. R.HALLIDAY

DR. RANTA: Mr. Chairman, ladies and gentlemen of the Commission, if I might introduce first of all the members of our organization who are appearing with me. On my left is Dr. Robert Halliday, who is Executive Director of the Foundation. He is a specialist in Psychiatry and will be able to deal with any of the clinical or surrounding clinical questions that you arise. On my right is Mr. Stewart McMorran who is a volunteer on the Board of Directors of the Foundation. In his working life he is City Prosecutor. I am appearing on this occasion as a voluntary lay person who at the moment happens to be President of the Board of Directors.

If I might take the liberty first, Mr. Chairman, to comment on submission you have just heard. I was very much impressed by the group of our elder citizens who came forward to speak for themselves about problems that relate directly to themselves. I think this was a very worthy effort that they made. Unfortunately on this occasion it is impossible, or it would be nearly impossible for the people who have a problem of narcotics addiction to appear before the Royal Commission. It is something that, I suppose, would be acceptable to the Royal Commission, but would be very difficult to organize and arrange for.

S U B M I S S I O N O F

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Consequently you have before you sort of second-hand people who are attempting to do something about what we consider to be a very serious and very difficult problem within our community and with a number of the major communities within Canada.

I just say this as a preliminary because there are certain aspects of narcotic addiction that we know nothing about, at least, I don't feel that the three of us have direct experience with narcotic addiction in the way I was referring to.

The submission that we make to you today, Mr. Chairman and ladies and gentlemen is a request for support from the Federal authorities. We are, at the present time receiving some support from Provincial authorities. I would like to refer to the last page of our submission, page 8 in which our recommendations appear.

1. It is urged that the Federal and Provincial authorities share in matching support of appropriate voluntary agencies for the construction and operation of suitable facilities devoted to programmes for the treatment and rehabilitation of narcotic addicts and for the prevention of narcotic addiction.

2. In view of the need for hospitalization of the narcotic addict during withdrawal therapy, it is urged that Federal authorities in their support of provincial hospital insurance schemes formally recognize the need for such hospitalization in suitably supervised areas in general hospitals and in this way encourage the development of a greater understanding among the medical and allied professions of the treatment of the narcotic addict.

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In the first section of our report we brought to the attention of the Commission that the problem of narcotic addiction was very reluctantly brought to the attention of the public only some ten years ago. There is a great deal of resistance to looking at it and bringing it out into the open, the question of narcotic addiction. We have faced this resistance and reluctance within the operation of our organization even to the extent of having considerable difficulty, perhaps considerable is a mild word, in even finding some place to carry out the modest degree of work we are able to do, even to find a residence to operate the only withdrawal service that is at the present time available in British Columbia, and possibly the only withdrawal service that is available exclusively for narcotic addicts and operated on an exclusive basis in the whole of Canada. We point this out only to indicate that there may be among the members of the Commission individuals who are not well versed in the problem of the narcotic addict. We wouldn't find this surprising at all because we find it even within our own community, within the section of the community such as the medical and the allied professions, that there is relatively little information that has permeated into its ranks. That is one of the reasons we feel that our second recommendation was most important, that the narcotic addict's problem should be brought into the general hospital scope, as it were, so that the doctors and the nurses and the allied therapists would become aware of the problems and the way in which to treat them so this information may permeate into the community and in that way we would get a better

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1 understanding of what the narcotic addict's problems are.
2 The other point that we are making is
3 that we need financial support. I think we stand on solid
4 ground that every dollar that is spent in this field in
5 the way that we suggest in this initial exploratory way is
6 saved many times over in the community. In other words it
7 is a good financial deal. We wouldn't say we can guarantee
8 but we would suggest that the return on the expenditure of
9 the dollar would be a profit to the community of some 66%
10 or more, which is a very good financial deal in anyone's
11 language, in terms of the figures we have of the reduction
12 of the amount of addiction even among those who are within
13 the treatment setting. It is on that basis that we rest
14 our case and I think that possibly I should at this stage
15 leave it up to the Commission that if there are any ques-
16 tions that my colleagues can answer we would be prepared
17 to take it as far as we can at the present time.
18 THE CHAIRMAN: This financial aspect
19 you are mentioning, that is referred to on page 5.
20 DR. RANTA: That is right, on page 5
21 in the middle of the page. This would seem to justify the
22 use of the taxpayers' money. If it is just counted against
23 the number of days of addiction that is provided to the
24 group of people who are under treatment, but not considering
25 the days, the many days that would be provided on an
26 accumulated basis to those who may decide to refrain from
27 the use of drugs over a longer period of time.
28 THE CHAIRMAN: What special problems
29 would have to be faced in this idea of bringing the drug
30 addict to the acute general hospital?

understanding of what the narcotic addicts problems are.

The other point that we are making is that we need financial support. I think we stand on solid ground that every dollar that is spent in this field in the way that we suggest in this initial exploratory way is saved many times over in the community. In other words it is a good financial deal. We wouldn't say we can guarantee but we would suggest that the return on the expenditure of the dollar would be a profit to the community of some 55% or more, which is a very good financial deal in anyone's language. In terms of the figures we have of the reduction of the amount of addiction even among those who are within the treatment setting. It is on that basis that we rest our case and I think that possibly I should at this stage leave it up to the Commission that if there are any questions that my colleagues can answer we would be prepared to take it as far as we can at the present time.

THE CHAIRMAN: This financial aspect you are mentioning, that is referred to on page 5.

DR. HOLLA: That is right, on page 5 in the middle of the page. This would seem to justify the use of the taxpayers' money. If it is just counted against the number of days of addiction that is provided to the group of people who are under treatment, but not considering the days, the many days that would be provided on an accumulated basis to those who may decline to refrain from the use of drugs over a longer period of time.

THE CHAIRMAN: What special problems would have to be faced in this idea of bringing the drug addict to the acute general hospital?

DR. RANTA: Would you like to deal with that, Dr. Halliday?

DR. HALLIDAY: I think one of the problems, Mr. Chairman, is something Dr. Ranta has brought to your attention, the general ignorance and, therefore, fear in regard to how does one manage this kind of problem. I think there are certainly more reality problems and it is that the addict, in many ways, of course, in his addiction is acting out various kinds of problems. It doesn't matter what setting he may be in. Therefore to obtain the kind of controls which he often requires isn't possible or not as easily possible in the general hospital setting. One, I think, would have to recognize there might be some addict that wouldn't fit into this kind of setting, although, I think even there there is a great deal to learn about this. It has been a traditional subject that many other kinds -- I am defining the addict as a psychological problem here -- many other kinds of psychological and psychiatric patients may not be managed at the general hospital.

And I think the experience has shown that this can be done if a suitable structure is devised to meet the function for which you are intending it. I think this would be so even with our chronic addict, too. This is possibly the main problem, a matter of control. I think that the controls are perhaps -- the fearing of this is greater than perhaps the situation actually warrants. We would have to learn about this.

THE CHAIRMAN: Would the cost of maintaining an addict in this withdrawal period in an acute general hospital be more than the average of another patient?

DR. RANTA: Would you like to deal with that, Dr. Halliday?

DR. HALLIDAY: I think one of the problems, Mr. Chairman, is something Dr. Ranta has brought to your attention, the general ignorance and, therefore, fear in regard to how does one manage this kind of problem. I think there are certainly more reality problems and it is true the addict, in many ways, of course, in his addiction is acting out various kinds of problems. It doesn't matter what setting he may be in. Therefore to obtain the kind of controls which he often requires isn't possible or not as easily possible in the general hospital setting. One, I think, would have to recognize there might be some addict that wouldn't fit into this kind of setting, although I think even there there is a great deal to learn about this. It has been a traditional subject that many other kinds -- I am defining the addict as a psychological problem here -- many other kinds of psychological and psychiatric patients may not be managed at the general hospital.

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THE CHAIRMAN: Would the cost of maintaining an addict in this withdrawal period in an acute general hospital be more than the average of another patient

DR. RANTA: Oh, no.

DR.HALLIDAY: I do not think so.

THE CHAIRMAN: Would more custodial care be required?

DR. HALLIDAY: I think custodial care is perhaps one of the cheapest forms of treatment. This would be my thinking about this. I think this applies, again, in any setting where one requires a good deal of personal relationship, which is really the key to the therapy eventually, that one requires a good deal of staff. But in terms of medications and things like that, this would be a relatively inexpensive form of treatment.

DR. RANTA: I do not know whether, Mr. Chairman, we may not be understanding each other -- it is recommended here that it is true the withdrawal therapy is not during the whole period of the treatment of the narcotic addict. This withdrawal period would be a relatively short time, and possibly Dr. Halliday might be asked to describe something about the withdrawal period in order to give us some idea of the time that would be involved.

THE CHAIRMAN: And would you perhaps add one factor to it. Supposing this idea was accepted, how many hospital beds would it occupy in British Columbia?

DR. HALLIDAY: The number of beds that would be required to try to deal with the problem, sir?

THE CHAIRMAN: Yes.

DR. HALLIDAY: I could not really give an answer at the present time. A lot would depend, of course, on how the addict comes into treatment. The presumption, I suppose, is that the addict would come

DR. HALLIDAY: I do not think so.

THE CHAIRMAN: Would more substitutes

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DR. FANTA: I do not know whether, Mr. Chairman, we may not be underestimating each other -- it is recommended here that it is true the withdrawal therapy is not during the whole period of the treatment of the narcotic addict. This withdrawal period would be a relatively short time, and possibly Dr. Halliday might be asked to describe something about the withdrawal period in order to give us some idea of the time that would be involved.

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THE CHAIRMAN: Yes.

DR. HALLIDAY: I could not really give an answer at the present time. A lot would depend, of assumption, I suppose, is that the addict would come

voluntarily for treatment at the general hospital.

THE CHAIRMAN: I just mentioned that. You go ahead with the other aspect you were going to deal with.

DR. HALLIDAY: Yes. One thing, perhaps, I could say, sir, is that I think any unit at all -- I believe this is true -- that the minimal medical unit in a nursing service is probably 20 beds. One could think of units with that, and perhaps that might be a minimum to begin with.

With regard to the withdrawal treatment, this is relatively simple, and while it is the key area in the treatment, it is probably in many ways of the least importance. It is a necessary beginning, although the patient might have to be brought along to the point where they are willing to accept this. We believe that the kind of medication that should be employed hinges around another narcotic, in which the individual is going to be gradually withdrawn from. The average addict is probably using five or six capsules of heroin a day, with the presumption that there is one-quarter of a grain of heroin, which is, of course, a very illegal drug and cannot be used, even with medical supervision. We can give them methadone, which is a synthetic narcotic, and starting off in small doses of 40 milligrams spread over a 24-hour period, we reduce this in about twelve days to nil. Along with that, we use some other tranquilizing agent, and some sedatives at bed-time.

The general nursing care in regard to meeting other symptoms, the patient is nursed in bed for four or five days, because three or four days is the most

voluntarily for treatment at the general hospital.

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1 difficult period. After that, it is relatively a minor
2 problem to achieve physical withdrawal.
3 The real problem remains after that,
4 to help the individual understand his problem. I think
5 at that point the patient could be moved to another kind of
6 treatment centre, but perhaps two or three weeks might be
7 all that is necessary in the acute general hospital setting.
8 DR. RANTA: If I might comment on the
9 size of the situation, Mr. Chairman -- the size of the
10 unit. This was not considered, as far as the Foundation
11 was concerned. What we are chiefly interested in is in
12 entre. At the present time, entre is barred to the
13 narcotic addict for withdrawal purposes.
14 THE CHAIRMAN: You see, if you get
15 entre, are we going to displace?
16 DR. RANTA: Yes, eventually one will
17 displace, but at the present time, if the patient is dealt
18 with, even only on one or two patients at a time, even on
19 some specially selected and supervised area, with these one
20 or two displacements, would be so advantageous in terms
21 of providing additional information for the medical pro-
22 fession and the nursing profession, that it would be a
23 worthy displacement, as it were.
24 COMMISSIONER BALTZAN: Dr. Ranta, I
25 am glad to see you again and again and again!
26 DR. RANTA: Thank you, sir.
27 COMMISSIONER BALTZAN: We have a saying
28 about the ladies, when they appear, that they are wearing
29 "many hats". From Dr. Bank's remark which we heard, for
30 gentlemen we say that they wear many shirts.

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The real problem remains after that, to help the individual understand his problem. I think at that point the patient could be moved to another kind of treatment center, but perhaps two or three weeks might be all that is necessary in the route general hospital setting.

DR. RAMTA: If I might comment on the size of the situation, Mr. Chairman -- the size of the unit. This was not considered, as far as the Foundation was concerned. What we are chiefly interested in is in entry. At the present time, entry is barred to the narcotic addict for withdrawal purposes.

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COMMISSIONER DALTON: Dr. Ramta, I am glad to see you again and again and again!

DR. RAMTA: Thank you, sir.

COMMISSIONER DALTON: We have a saying about the ladies, when they appear, that they are wearing "many hats". From Dr. Bank's remarks which we heard, for gentlemen we say that they wear many shirts.

It is interesting here to note this: Why do half of the Canadian narcotics gravitate to Vancouver? Is there any known reason?

DR. RANTA: I wonder if Dr. Halliday could deal with this. This is a question that has been raised on occasion, so I am sure that Dr. Halliday will be able to satisfy the Commission on this.

DR. HALLIDAY: I do not feel that I can answer the question by any means fully, but I would take issue with the statement that they gravitate towards British Columbia. I do not think this is in fact the case.

If you are familiar with the Stevenson Research Study on Narcotic Addiction which was done about five or six years ago, Dr. Stevenson at that time did find out that about 80% of the addicts that were studied, and about 500 were studied, naturally were born, bred and brought up in British Columbia. This is not a problem of geography, and things like that, in that sense.

We know that narcotic addiction is a symptom. It is not in itself -- it is not a process. It is a symptom of individual disturbance, and we feel it is a symptom of social disturbance, and in our society we find confirmation of this. We find in our society we have a great number of what we might call "social disorders", which stand at their peak insofar as comparative studies with the rest of the country are concerned. We have delinquencies, illegitimacy, mental hospital admissions, alcoholism, suicide. Somebody says "You name it and we have got it", and this is unfortunately the truth.

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DR. HADLEY: I do not feel that I can answer the question by any means fully, but I would take issue with the statement that they gravitate towards British Columbia. I do not think this is in fact the case.

If you are familiar with the Stevenson Research Study on Narcotic Addiction which was done about five or six years ago, Dr. Stevenson at that time did find out that about 60% of the addicts that were situated, and about 500 were studied, actually were born, bred and brought up in British Columbia. This is not a problem of geography and things like that, in this sense.

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I think there is a very positive

correlation between addiction and all these other medical social problems. The why of this -- this is an area in which a great deal of study and research is still required, and unfortunately this has not been done. We are hopeful that within this next year we shall be able to bring from our own study some of the the demographic and natural history studies of this problem as it may relate to some of the other social studies, too.

COMMISSIONER BALTZAN: This leads me to ask another question, but I am not going to ask it. According to your explanation, why is there so much more of these social contributory disturbances centred here rather than elsewhere -- but I am not going to ask that.

You speak of institutions, and you want areas where these people can obtain fall-off treatment, etcetera. My question is not in the form of anything more than clarification. Would institutions known for that purpose be detracting to the individual, or would it be attracting, knowing he is going to go to a narcotics centre, let us say, and such as people have objections in going to a mental hospital. Would it be better that they might go to the outdoor of a general hospital only to another department, rather than to an institution?

DR. RANTA: I might attempt to begin the answer to the question, and then perhaps turn over another portion to Dr. Halliday.

I think we must take into consideration the reality of the situation as it exists now. The narcotic addict is not really welcome anywhere. To go through the process of attempting to educate the whole of

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DR. HILLIAR: I might attempt to begin the answer to the question, and then perhaps turn over another portion to Dr. Matilda.

I think we must take into consideration the reality of the situation as it exists now. The narcotic addict is not really welcome anywhere. To go through the process of attempting to educate the whole of

the community; to educate the medical and nursing professions, I think that we may have to take the first step in the development of a specialized institution for this kind of care. This may ultimately lead to acceptance, as has now happened in the mental health field, the acceptance of these individuals into special portions of general hospital set-ups.

I think that we are suggesting two things here. Initially, we suggest the institutions that we need at the present time, which would still be on a research and learning basis. At the same time, we wish to have some little access to the general hospital set-up in order to have the education going along concurrently with the things that we find. I think that this is, perhaps, the best way that we could answer this precise point.

I would agree, and I would like Dr. Halliday to elaborate on this, but I would agree that this might be the objective in the end. Whether it is achievable or not, I think Dr. Halliday would have to deal with that.

DR.HALLIDAY: There is one other point here, Mr. Chairman, that I feel has got to be taken into consideration. Again, as Dr. Ranta points out, the reality of what is going on now, and that is unless there were some other form of compulsion, and there is a great deal of discussion about this, the majority of addicts will either be on the street using drugs, or they will be in jail because they have committed some offense, whether this is in regard to the Narcotic Drug Acts or not. We know a great number are in jail at any one time -- perhaps four

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or five in this Province. It should not be a matter that they are just in jail because this is going to give no answer to the problem.

The Federal Government is thinking of establishing a treatment institution, and I think it is considering in the matter of what the reason may be that an individual has got into jail or into prison. If he is a known addict, provision should be made for his treatment there.

I think many will be treated in such an institution. There are many, as we see them, looking for this service. We are able to make some attempt to help them both in an outdoor setting and with the very small facilities available in our residence. We see our patients, most of them, with some kind of psychological disturbance, and they have many medical problems, and there should be facilities available in available psychiatric services, whether in general hospitals or in the mental health services for the reception and treatment of these patients.

This may require specialist wards or units within the mental health service, or within general hospital systems.

This, of course, beyond the period when a person requires to be in a closed setting or a fully protective setting. I think there have to be other kinds of half-way houses in the community.

COMMISSIONER BALTZAN: Is narcotics addiction reportable here, as venereal disease is in some provinces?

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addiction reportable here, as venereal disease is in some provinces?

DR. HALLIDAY: No.

COMMISSIONER BALTZAN: Would that be helpful?

DR. RANTA: I think, Mr. Chairman, the difficulty that we would have in this is that relatively few doctors see narcotic addicts, and I do not think that this would add very much to the statistical evaluation of what the problem is.

I think that our Foundation has a great deal of information with respect to the numbers of people, as you will notice from the annual report which we submitted and from the brief.

I do not know that the figures would be much improved over what we are able to get from the law-enforcement agencies who eventually become the statistical service for this. Recognizing that there are so many addicts in the community, one can just interpolate into that how many they do not know about. On the basis of the findings that an addict has been an addict for four or five years before he has been caught doing some criminal act, one can only interpolate on that as to how many years he has been an addict.

I was wondering, would it be of value to the Commission to hear from Mr. McMorran with respect to the impact of this. We come back again to this problem of whether it is worthwhile paying the taxpayer's money out to support this kind of program, and to take some description of the impact that narcotic addiction has on the community, outside of the effect it has on the narcotic addict himself.

DR. HALLIDAY: No.

BAUMAN: Would that be

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THE CHAIRMAN: Yes, Mr. McMorran:

MR. McMORRAN: Mr. Chairman and Miss Girard and gentlemen, I realize, and I think we all appreciate in our society, that the Commission is not here to examine in detail the narcotic problem in Canada. I believe, however, that you should have some inkling of what really the problem is in order to fully appreciate the need for financial support along the lines our society has suggested.

Now, if we recognize, first, that in Canada there is no other agency that I am aware of, except the Narcotic Addiction Foundation of British Columbia for the assistance to addicts in various fields, number one, to find out what this subject is all about; number two, to protect the community from the vagaries of addicts in the crimes committed by them in the requirement of obtaining funds to support their habit; and number three, and perhaps incidental -- it depends on which side of the fence you are on, I suppose -- incidentally, anyway, the assistance to these people who are social outcasts if they happen to be criminal addicts.

Some people do not believe that there is any hope of saving criminal addicts; other people take the opposite stand. There is no question that in the course of time this Foundation has been in operation, as was pointed out on one of these pages here, page 5, there were 3,755 days of abstention, and that is a minimal, and our budget last year was about $90,000.00. We figure that there is a saving of $136,000.00 in costs to merchants and the community in general, and the members of the public

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whose houses are broken into every night in the City and in other cities, too, where they have this problem. This is a problem where the addict must get enough money to support his habit. That can easily be figured out to come to approximately $10,000,000.00 a year. In this area, where there are approximately 2,000 addicts, it is supposed that half are in jail, and supposing it cost say minimal average of $30.00 a day to support an addict, that the money has to come from somewhere. A good chunk, of course, comes from the sale of women's bodies on the streets, but nevertheless, there is a tremendous amount of money lost by merchants and householders in thefts and that class of crime in order for addicts to support their habits.

/ss Every man in this room who is wearing a tie and shirt can figure he is spending an additional fifty cents to $1.00 because of the thefts that occur in our country because of narcotics. I do not think there is any question about that at all.

I come back to one final point in this regard; in Canada there is not one society or organization devoting itself to the determination of this problem as far as it is possible to do so. We have a major problem in Canada and I suggest to you that it would not be proper to allow anyone to get away with any thought that this province has the only narcotic problem. I do not know how other places keep their statistics, but there is no question that the narcotics do not come into Canada by way of British Columbia, they come into Canada by way of Eastern Canada. This does not mean to say we do not like the people in Eastern Canada, but there is a problem there

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as well. There is no doubt about that.

It seems to me that if we have a problem in this country it has to be resolved for one of two reasons; either the Governmental agencies, either Provincial or Federal, believe it is a good thing to attempt to save the people who are addicts or it is a good thing to protect the other people from the vagaries of the addict. I do not hesitate to say either if the high incidence of drug addiction were reduced that there would be a reduction in the relatively high incidence of certain classes of crimes, thefts and breaking and entering and that sort of thing. Ordinarily speaking a heroin addict is not a violent person; that does not mean to suggest some of them do not become violent but the crimes committed in that regard are not frequent. Drug addicts are ordinarily not addicted further to violent crimes, but they must get the money to support their habit someplace. As was suggested to me before we came up to the table here, if the drug addiction is down and the crime is down there are fewer jails and eventually we hope fewer persons in those jails and perhaps even fewer prosecutors which would probably be a good thing.

COMMISSIONER FIRESTONE: Dr. Ranta, in your recommendation number 1 you suggest having agencies for the construction of suitable facilities for the treatment and rehabilitation and prevention of narcotic addiction. That is a worthwhile suggestion and if it was implemented it would assist you to deal with some of the symptoms of drug addiction. What I would like to ask you is, could you visualize some steps to deal with the causes of drug addiction?

as well. There is no doubt about that.

It seems to me that if we have a [illegible] two reasons; either the [illegible] Provincial or Federal, believe it is a good thing to attempt to save the people who are addicts or it is a good thing to protect the other people from the vagaries of the addict. I do not hesitate to say either if the high incidence of drug addiction were reduced that there would be a reduction in the relatively high incidence of certain classes of crimes, thefts and breaking and entering and that sort of thing. Currently possessing a narcotic addicter is not a criminal person; that does not mean to suggest some of them do not become violent but the crimes committed in that regard are not frequent. Most addicts are ordinarily not addicted further to violent crimes, but they must get the money to support their habit somehow. As was suggested to us before we came up to the table here, if the drug addiction is down and the crime is down here in our jails and eventually we hope fewer persons in these jails and perhaps even fewer prosecutions which would probably be a good thing.

[illegible]

In your recommendation number 1 you suggest having programs for the construction of suitable facilities for the treatment and rehabilitation and prevention of narcotic addiction. That is a worthwhile suggestion and if it was implemented it would assist you to deal with some of the symptoms of drug addiction. What I would like to ask you is, could you visualize some steps to deal with the causes of drug addiction?

DR. HALLIDAY: As I have indicated, I think that drug addiction is a symptom in itself, not only in the individual of various kinds of personality and psychiatric disorders, but by association and within certain kinds of a community it becomes a social problem. There is certainly association with a great number of other problems and we have a great deal to learn about this as to why it is so. I do not think we really understand this, that we have even begun to understand it. We can only say it is the way it is, so we do need this kind of work to be done. This is the type of centre needed in this province, but it is certainly necessary other places as well.

DR. RANTA: I think the important point we would make in asking for this support is that the Foundation is not planning to cope with the whole problem. The Foundation is planning to learn about the problem and I think the answer to the question you posed to us will only come after we have received adequate support to get the beginnings of the answers that we are seeking at the present time with inadequate support.

COMMISSIONER FIRESTONE: If there were more comprehensive psychiatric care available under a comprehensive medical care plan would such psychiatric care assist in dealing with some of the causes of drug addiction?

DR. HALLIDAY: It would in terms of the individual, certainly, I have no doubt about this. In my own clinical experience both with this type of person and the type of related disorders I think unless along with this there are studies of things like the epidemiology and so on which would give us some clue as to the social

DR. HAMILTON: As I have indicated, I

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CHAIRMAN FINNSTROM: If there were more comprehensive psychiatric care available under a comprehensive medical care plan would much psychiatric care assist in dealing with some of the causes of drug addiction?

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factors involved we begin to see why and what problems are related to this and it would help us to plan for preventive programs.

COMMISSIONER FIRESTONE: That is a very helpful answer, thank you.

COMMISSIONER GIRARD: There seems to be a growing concern about increases of drug addiction among the younger age group, high school group and a little older. Do you feel this is a real concern? Did you find something in your studies on addiction here that would substantiate that?

DR. RANTA: I would like to turn this question over to Dr. Halliday because we have information on these lines and we certainly have concern about it and he would be able to present the facts as have them.

DR. HALLIDAY: We know that in our own area and in areas like New York where this drug addiction problem is very high statistics do indicate that younger people are becoming more and more involved. In Vancouver we do see a great number of people, speaking comparatively here, a great number of people, young people who have not been identified and become statistics in any way who are under the age of 20 and who have been addicted for some time. The youngest patient I have seen was a girl of 15 who had been addicted for two years. Whilst this is uncommon, it is not unique. We know there are over two hundred and this is a more or less figure, because there are not statistics, people under the age of 20 who are addicted and have been addicted for some time, some of them for four or five years. What we do not know is how

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many others there are who may be similarly affected and there may be two or three times that many but we really cannot say. The statistics from various centres do indicate that younger people are becoming involved and it is true in delinquent behavior generally.

DR. RANTA: Our last annual report will show that we had contact with 209 new patients and nearly 50% of these were addicted before the age of 20.

COMMISSIONER GIRARD: Thank you very much.

COMMISSIONER STRACHAN: If we had ideal treatment institutions or centres is there any compulsive means of getting the patients into these institutions or should there be?

DR. RANTA: Mr. Chairman, this is a matter that has not yet been clarified as far as British Columbia is concerned. There is, however, a possibility for this provided the Province agreed within the new Federal Drug Act. Our organization, however, we would stress, is a voluntary organization in the sense that we are working with the addict who voluntarily comes to us and stays. That is, we are unique in this respect. We were told that this could not work, it was impossible but has gone on from time to time and our statistics last year show that 71.7% of the addicts that came in remained to complete their withdrawal. This is what we were told would not have been possible. We realize it is possible because of the fact that it is a voluntary program and, secondly, that it was voluntary in our regard as well. In other words, we selected from among the voluntary

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individuals who came in in order to insure that we would be able to get the greatest value for the effort in terms of learning about what narcotic addiction is all about. I think we would not be prepared at this time as a Foundation to have an opinion that there should be compulsory service, at least compulsory service to the addict. If we did that within the Foundation it would make our Foundation very different from the learning type of organization it is now because we would have become a service organization and with 2,000 people that we would have to cope with, within our submission here, we would be wholly unable to provide any kind of service for the particular kind of population. Perhaps when you gentlemen or your counterparts in ten years time come around to review the problem again then in those circumstances we might have more to suggest in terms of additional facilities that may be necessary.

THE CHAIRMAN: Thank you very much, Dr. Ranta, Dr. Halliday and Mr. McMorran. We appreciate your attendance here and your brief. We will recess now until two o'clock.

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THE CHAIRMAN: Thank you very much, Dr. Jones, Dr. Halliday and Mr. McMorran. We appreciate your attendance here and your brief. We will recess now until two o'clock.

THE CHAIRMAN: Mr. King.

THE SECRETARY: This will be number 178..

---EXHIBIT NO. 178: Submission of the Western District Union, International Union of Mine, Mill and Smelter Workers (Canada)

S U B M I S S I O N O F

THE WESTERN DISTRICT UNION, INTERNATIONAL UNION OF MINE, MILL AND SMELTER WORKERS (CANADA)

APPEARANCES:

MR. A. KING

MR. KING: This is a submission to the Royal Commission on Health Services submitted by the Western District Union, International Union of Mine, Mill and Smelter Workers.

It has been said that a country's greatest asset is its people. This being so, the health and welfare of the people should be the country's greatest concern.

In this connection we welcome the appointment of this Commission whose studies and investigations we know will result in a positive step further along the path of progress in the vital matter of health protection for all Canadians.

Although this Union's interest in health services for all Canadians is general and wide-ranging, we are restricting our submission at this time to two main topics; i. e.

THE CHAIRMAN: Mr. King.

THE SECRETARY: This will be number 176.

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1. Improved Industrial Hygiene Protection for all Canadian workers.

Present facilities inadequate.

2. Provision of Sick Pay Benefits to Canadian workers.

Existing provisions inequitable and largely inadequate.

In concluding this summary it is necessary to record the fact that the position of this Union respecting general health services has been maintained in Convention action down through the years and has been registered with the respective Governments both Provincially and Federally.

"That the Federal and Provincial Governments underwrite a comprehensive medical care plan for all Canadians irrespective of individual economic circumstance."

INTRODUCTION: This Brief is submitted by the Western District Union of the International Union of Mine, Mill and Smelter Workers. This Union represents the employees in the mining industry and has represented the workers in this industry for decades and decades of years. Mining is a national industry and has many natural hazards with which we, as a Union, have had to concern ourselves in the interests of our membership and their families.

The terms of reference of this Commission, a copy of which we have been provided with, are so wide and all-embracing that literally every possible matter affecting the health and welfare of Canadians would appear to be suitable material to bring forward.

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injured and industrially sick workmen who are experiencing severe difficulties with the various Compensation Boards of the country. We are, however, restricting our submission to the two points as summarized. We feel that it is necessary for this Commission to study these vital matters before bringing in recommendations to the Government.

We feel our submissions today would fall within some of the stated terms of reference; i.e. (a), (b), (c), (d), (f), (g), (j), with respect to industrial hygiene, and (c), (g), (h), (i), with respect to sick leave.

INDUSTRIAL HYGIENE:

This Union proposes the establishment of a centralized division of industrial hygiene, sponsored by the Federal Government and involving the provinces. We do so on the following grounds, and we make clear at the outset that there is not involved here any criticism implied or otherwise of any of the personnel of existing industrial hygiene organizations in Canada.

At present there is a Department of Industrial Hygiene functioning as a branch of the Department of Health in Ottawa. There is also one in the Province of Ontario under similar framework and other provinces to the best of our knowledge may have some degree of organization in association with provincial Departments of Health or Compensation Boards, the latter being the case in the Province of British Columbia.

As an example of what co-operation between departments of Government can accomplish, we attach to this brief a copy of the recommendations of the Silicosis

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As an example of what co-operation between departments of Government can accomplish, we attach to this brief a copy of the recommendations of the Ontario

Committee appointed by the Associated Compensation Boards of Canada. The recommendations of this Committee have been endorsed wholeheartedly by our recent District Convention and we strongly urge the implementation of these recommendations as quickly as possible.

THE CHAIRMAN: You are putting that in?

MR. KING: Has it not been filed with the Commission?

THE CHAIRMAN: The Silicosis Committee?

MR. KING: I am sorry, that must have been an oversight. It is the reciprocal treatment of silicotic workmen. I will file that later. I think there has been an oversight.

From our own experience we know that there is unequal development of industrial hygiene organization and services. Taking British Columbia as an example, we are told that the Industrial Hygiene section, functioning under the Workmen's Compensation Board Commissioners, comprises one, or at the most two individuals. Any real problem affecting the workmen of this Province from an industrial hygiene point of view of any magnitude, has had to be dealt with by appeals to outside organizations. This Union has lodged strenuous proposals for several years to the Government of British Columbia for the establishment of a separate Department of Industrial Hygiene, fully staffed and equipped to serve the interests of all B.C. workmen. We were encouraged by the then Minister of Labour Mr. Lyle Wicks to maintain pressure on the Government in view of his personal conviction that our views were well-founded and should be acted upon by the Government. Indeed,

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the only reservation placed by Mr. Wicks upon our recommendations was that such an industrial hygiene department would be separated from the existing bodies such as the Compensation Board and Provincial Department of Health, but would work in co-operation with them as a separate entity. To date the B.C. Government has not seen fit to take any action in the matter.

We would here, in support of our position, file correspondence between a Local of our Union, the Consolidated Mining and Smelting Company, and the appropriate authorities in the Department of National Health in Ottawa, and the Provincial Department in Toronto. The dates should be noted so that the lengthy delay in action is understood.

This is the file of correspondence, Mr. Chairman.

THE SECRETARY: Exhibit Number 178 A.

---EXHIBIT NO. 178-A: File of Correspondence between a Local of the Union, the Consolidated Mining and Smelting Company and appropriate authorities.

The next Exhibit we would like to file with the Commission is the study that resulted from the foregoing correspondence and which the Commission will see constituted a work of considerable proportions. That is it.

THE SECRETARY: 178 B.

---EXHIBIT NO. 178-B: Investigation of respiratory cancer mortality by Dr. R. B. Sutherland for a period in 1930-1957.

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The next Exhibit we would like to file with the Commission is the study that resulted from the foregoing correspondence and which the Commission will see constituted a work of considerable proportions. That is

THE SECRETARY: 178-B.

Needless to say, the recommendations were acted upon with alacrity by the Company and the Union and although the three named widows were statute-barred from their widows' compensation under the Provincial Act, the Company has seen fit to grant such coverage. I might digress a little, Mr. Chairman, to explain this phase of the incidence of lung cancer among long-term employees of the Consolidated Mining and Smelting Company and the Silver Company and mining plant at Trail, that was the reason for the institution of this study by this doctor. Those are the results that have been filed today.

There continues to be further study by Dr. Sutherland of the phenomena of fibrosis of the lung as a consequence of lengthy exposure to these plant conditions. Before leaving this question, we would make the comment that Dr. Sutherland's capabilities should not be restricted to the Province of Ontario; should not be removed from the needs of Canadian workers by the red-tape which had to be overcome in obtaining his services for this study and such a qualified person could be an important figure in the centralized industrial hygiene apparatus that we are proposing here. The training that he would be able to pass along to others would be of tremendous benefit to the scientific studies of the industrial hazards and prevention of same and surely from every viewpoint, would be in the best interests of Canada as a whole.

It will be noted in the particular problem referred to in the Exhibited correspondence that several years elapsed before a relatively satisfactory solution was arrived at, and the area of hazard or potential

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It will be noted in the particular problem referred to in the exhibited correspondence that solution was arrived at, and the area of hazard or potential

hazard reduced to the satisfaction of all concerned, if not, as time only will prove, altogether eliminated.

We are reasonably sure in the light of our own experiences, that other lesser industrialized provinces than Ontario and British Columbia are probably less equipped organizationally and materially to supply the type of industrial hygiene service that the Canadian worker should rightfully expect. Skilled clinicians, industrial hygienists, pathologists, statisticians, and others scientifically qualified are necessary to adequately cope with the growing number of industrial hazards that are engendered, as the industrial potential of our nation increases, and native industry accelerates its expansion. Our Union is not satisfied with the type of service now available to Canadian workmen.

There are many maladies and potential ones threatening Canadian working men today and we feel that there has not been, and is not enough study being devoted to the problems thus engendered. We feel that there should be a central organizational apparatus whereby it would be unnecessary for inter-provincial, inter-departmental clearances and approvals and the severing of red-tape which is at present necessary before action is taken on a problem involving the health of Canadian workers. From the time element alone, if it is found that workers are being subjected to prolonged exposure of industrial hazards, surely the sooner this is determined the better, and the men removed from the area of hazard or the hazard itself worked upon with a view to reduction or elimination, and we feel that a central, fully equipped organization, such as we propose would reduce the danger of prolonging

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exposure to any industrial hazard and that an expeditious organization could be maintained that would give maximum protection the the health of Canadian workmen regardless of the industry in which they are engaged.

Uranium mining & Processing, with a potential radiation hazard, comes quickly to mind and also the dread Reynaud's Phenomena to which more and more of our members in the uranium mines in northern Saskatchewan are falling victim. There are probably many, many other hazards in the variegated industries in a growing nation such as Canada and we feel the present industrial health and hygiene organization requires revamping.

This Commission must know by now that the provinces themselves, with possibly one or two exceptions, are unable to cope in an adequate way in these matters of such grave importance to the workmen in this country. Indeed, it is self-evident that the centralization of these services as we suggest, either completely under the Federal auspices or in conjunction with the more advanced provinces' organizational set-up, would tend to avoid some duplication and possibly a more complete industrial hygiene service could be provided for all Canadians instead of the present unequal services that depend upon the provinces' industrial capacity and therefore the economic ability to provide.

It should be mentioned that certain individual mining companies and the miner's Union have devoted some energy, time, and expense into such industrial hazards as silicosis and other chest conditions, metallic poisoning such as lead, with the main object of instituting

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preventative measures. The McIntyre Research Foundation sponsored serious studies and the introduction of the aluminum dust therapy, a preventative measure against silicosis, was introduced and is still being used although it is too early to judge its effectiveness.

We are not satisfied that no further steps have been taken to develop other possible preventative measures. We are firmly convinced that problems such as these could come within the scope of the National Research Council, which, together with a centralized Industrial Hygiene Division, in association with the Department of National Health for the Dominion of Canada would, we believe, be best able to cope with the present and potential industrial hazards of an expanding industry in a growing Canada.

SICK PAY BENEFITS:

There is a distinct necessity for protection for Canadian workmen when being afflicted with sickness or injury that is unconnected with the occupation of the individual. This Union is encouraged in outlining our position on this very important matter by the remarks of the Chairman at the preliminary meeting of the Commission as outlined on Page 3 in which two main points are stressed: That is Page 3 of the Minutes of the Preliminary Meeting, Mr. Chairman.

1. The financial burden that falls on the individual where no sick pay plan is in effect, and

2. The economic loss to the family and the community by the removal of the individual from his employment.

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2. The economic loss to the family and the community by the removal of the individual from his

This Union would go one step further in stating that if a Canadian workman requires a certain standard of living when he is well, that he certainly should not receive less when he is sick and although we as a Union have studied many forms of sick pay protection, we do not know of one Canadian workman, with possible exceptions in the salaried class, that does in fact receive full pay from any source when he is afflicted with sickness or accident unconnected with the job.

Our review of government statistics shows that whereas the percentage of Canadian workmen covered by paid sick leave plans is in the neighbourhood of about four out of every five being covered in the manufacturing industry, the metal mining industry provides between 85% and 90% coverage.

A review of the collective agreements between this Union and the mining companies with whom we deal, indicates that there is an extremely wide divergence in the coverage enjoyed by employees of different companies; the minimum figure being $30 per week for so many weeks and the highest being the novel paid sick leave plan that was initiated in the Consolidated Mining and Smelting operations last year.

We are filing at this time with the Commission a copy for their study as we feel it will be helpful to the Commission in their review of this question as it affects Canadian workmen. Thus it will be seen that existing plans fall far short of what is required to maintain a workman and his family during periods of absence from his job because of sickness.

In stating that if a Canadian workman requires a certain standard of living when he is well, then he certainly should not receive less when he is sick and although we as a Union have studied many forms of sick pay protection, we do not know of one Canadian workman, with possible exceptions in the salaried class, that does in fact receive full pay from any source when he is afflicted with sickness or accident unconnected with his job.

Our review of government statistics shows that whereas the percentage of Canadian workmen covered by paid sick leave plans is in the neighbourhood of about four out of every five being covered in the manufacturing industry, the metal mining industry provides between 85% and 90% coverage.

A review of the collective agreements between this Union and the mining companies with whom we deal, indicates that there is an extremely wide divergence in the coverage afforded by employees of different companies; the minimum figure being $10 per week for so many weeks and the highest being the novel paid sick leave plan that was initiated in the Consolidated Mining and Smelting agreement.

We are filing at this time with the Commission a copy for their study as we feel it will be helpful to the Commission in their review of this question as it affects Canadian workmen. Thus it will be seen that existing plans fall far short of what is required to maintain a workman and his family during periods of absence from his job because of sickness.

I would like to file copies of these which provide a minimum of three-quarters of the workmens' pay for, I couldn't say unlimited, but almost unlimited periods. It is a cumulative sick pay based on one day per month of service which pays three-quarters of the pay tax-free.

THE CHAIRMAN: What do you mean by that?

MR. KING: These sick pay benefits are not taxed.

THE CHAIRMAN: Are not taxable?

MR. KING: No.

THE CHAIRMAN: Why is that?

MR. KING: The monies to provide this benefit is paid to the employee by the company as part of his gross earnings and as such is taxed at source, and therefore the benefit itself is not taxed. In connection with this I would file the I.W.A. Plan which demonstrates the difference in benefits where they pay $35.00 a week for a maximum of 26 weeks with a waiting period of six days. A study of our By-laws will show there is only a three-day waiting period. We hope to reduce that. I would like to file this as an example of some other plans.

---EXHIBIT NO. 178-C: By-laws of the Consolidated Employees Benevolent Society.

---EXHIBIT NO. 178-D: Health and Welfare Plan for the Forest Industry.

In connection with the Commission's interest in the matter of financing of such sick pay cover-

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In connection with the Commission's interest in the matter of financing of such sick pay cover

age, our figures would indicate that between four and five cents per hour per employee would amply provide such coverage and maintain a surplus fund for emergency.

The reason for this, Mr. Chairman, is that although the Trail, and the Kimberley Plan has only been in operation for one year, for that period they have a surplus of $96,000.00 by a group of some 3,000 participating employees.

Whereas most list sick leave plans are carried by Insurance Companies that are in the business of making money for their shareholders, it will be seen that when this element is removed as is the case in the C.M.&S. employees' benevolent set-up or sick leave plan, considerable savings thus effected are enjoyed by the worker.

This Plan, the By-Laws of which are placed in Exhibit today, has functioned for many years and has been policed and administered by the workers themselves; a truly unique and effective method of organized sick pay protection for Canadian workers.

Should this Commission, after due consideration recommend the extension of adequate protection for sick Canadian workers, we of this Union are sure that our Plan in the CM&S operations in East and West Kootenay, Trail and Kimberley, may provide some useful information' and guidance therein

All of which is respectfully submitted,

By the Western District Union,
signed Al King, District Secretary

THE CHAIRMAN: Thank you very much, Mr. King, for a very lucid submission dealing with the two

age, our figures would indicate that between four and five cents per hour per employee would amply provide such cover age and maintain a surplus fund for emergency.

that although the Teck and the Kimberley plan has only been in operation for one year, for that period they have a surplus of $50,000.00 by a group of some 3,000 participating members.

Where most sick leave plans are operated by Insurance Companies that are in the business of making money for their shareholders, it will be seen that when this element is removed as is the case in the C.M.S. employees' benevolent set-up or sick leave plan, considerable savings thus effected are enjoyed by the worker.

This plan, the By-laws of which are placed in exhibit today, has functioned for many years and has been policed and administered by the workers themselves a truly unique and effective method of organized sick pay

Among this Commission, after due consideration recommend the extension of adequate protection for stick Canadian workers, we of this Union are sure that our Plan in the C.M.S. operations in East and West Kootenay, Teck and Kimberley, may provide some useful information and guidance therein.

All of which is respectfully submitted,

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THE CHAIRMAN: Thank you very much, Mr. King, for a very lucid submission dealing with the two

aspects of the problem to which you directed attention in this brief.

THE CHAIRMAN: Now, at the conclusion of your summary you refer to the policy that has been adopted from year to year that the Federal and Provincial Governments underwrite a comprehensive medical care plan for all Canadians regardless of the individual's economic circumstances.

Accepting for the moment that such a plan should be inaugurated, how do you see the plan such as is suggested by the Union with the various employers, how do you see these plans being integrated into a Federal-Provincial comprehensive medical care plan? What is to become of those plans that are now in existence?

MR. KING: Well, Mr. Chairman, I would like to say that I have been associated with CM&S for twenty-five years, and during this whole period we have had such protection of collective sick plan and a hospital plan, and I would just merely assume that were such a national plan instituted that there would be no more difficulty over that than the institution of the national hospital plan, which also took over --

THE CHAIRMAN: Just what happened when the hospital plan went into effect?

MR. KING: We just ceased that portion of our welfare coverage in our collective claims. We had a system whereby the company paid a portion and the employee paid a portion for hospitalization.

THE CHAIRMAN: Supposing a plan did not go so far as to include sick pay benefits, but only

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Accepting for the moment that such a plan should be inaugurated, how do you see the plan such as is suggested by the Union with the various employees, how do you see those plans being integrated into a Federal Provincial comprehensive medical care plan? What is to become of those plans that are now in existence?

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THE CHAIRMAN: Supposing a plan did not go so far as to include sick pay benefits, but only

provided for the health services -- I mean, physician services, dentists, drugs, and that kind of thing?

MR. KING: Well, that is what I thought your question was. I did not think of associating the question of sick leave pay with the question of sick leave paid care -- surgical and medical care is separate.

THE CHAIRMAN: The two can be kept completely separate?

MR. KING: I should imagine they would have to be.

COMMISSIONER McCUTCHEON: What are the monthly dues?

MR. KING: You will see in this plan that it is two plans.

THE CHAIRMAN: Yes. You were going to separate it. What would the monthly dues be for the sick benefits?

MR. KING: In the first place, when I refer to the 75% of pay, this only came in last year, although the plan itself has been functioning for some twenty to thirty years. I think it was 1926 when it started, actually, and the dues per member were $1.50.

COMMISSIONER McCUTCHEON: Per month?

MR. KING: Per month, and the company paid $1.50 per month.

THE CHAIRMAN: Did that include the family?

MR. KING: No, just the workman himself.

THE CHAIRMAN: What are we talking about? The sick leave or the hospital leave?

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THE CHAIRMAN: What are we talking about? The sick leave or the hospital leave?

MR. KING: We are speaking of sick leave.

THE CHAIRMAN: All right, thank you.

MR. KING: The medical care separately would cover the whole family, as we have established.

COMMISSIONER McCUTCHEON: The employee's contribution to this --?

MR. KING: At the present time, the employee's contribution to this plan is $1.75 and the company's contribution is $1.50 per month, but the new plan that was instituted last year is paid into a fund by the amount of 1.2% of the employee's earnings on top of that, which provides these additional benefits.

Our old plan, for instance, provided up to two years sick pay with a maximum of $7.00 per day in the second year.

You will see by a study of the rules that it starts out at $3.00 and it is staged up as the stages of the illness have passed. But we do not think that is possible to provide any better sick pay coverage than when the workmen themselves administer and police their own plan, as they do here.

THE CHAIRMAN: You are asking for an investigation -- you say you have lodged proposals with the Government for the establishment of the Department of Industrial Hygiene for an investigation into many aspects of the Workmen's Compensation features?

MR. KING: Yes.

THE CHAIRMAN: Now, are you aware that the Government of British Columbia has set in motion the

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MR. KING: Yes.

THE CHAIRMAN: Now, are you aware that the Government of British Columbia has set in motion the

machinery for such an investigation?

MR. KING: We are very aware of that.

THE CHAIRMAN: That is just recently?

MR. KING: Yes, as a matter of fact, it was directly as a result of our representations.

THE CHAIRMAN: So that, to that extent, this part of your brief has been taken care of?

MR. KING: That had a bearing on the substance of our brief to this Commission today, otherwise I feel we would have had a much more lengthy and exhaustive representation here today.

THE CHAIRMAN: Yes. Thank you.

COMMISSIONER FIRESTONE: Mr. King, if I may come back to this paragraph the Chairman referred to. It is the last paragraph on the first page of the summary. And you say that your Union endorses the recommendations that the Federal and Provincial Governments underwrite a comprehensive medical care plan for all Canadians irrespective of individual medical circumstances.

Could you explain to us what your Union has in mind when it speaks of the Federal and Provincial Governments underwriting a plan?

MR. KING: Well, in this connection, Mr. Chairman, I would like to refer to the separate letter dated February 17 was submitted by the President of this District, in which he refers the Commission to the possible constitution of road-blocks or complications that would be involved in the submissions we made.

When we refer, therefore, to the Federal and Provincial Governments underwriting, that would

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THE CHAIRMAN: Yes. Thank you.

COMMISSIONER FRESTONE: Mr. King, if I may come back to this paragraph the Chairman referred to. It is the last paragraph on the first page of the summary. And you say that your Union endorses the recommendations that the Federal and Provincial Governments undertake a comprehensive medical care plan for all Canadians irrespective of individual medical circumstances.

Could you explain to us what your Union has in mind when it speaks of the Federal and Provincial Governments undertaking a plan?

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When we refer, therefore, to the Federal and Provincial Governments undertaking, that was

1 involve the setting aside of the constitutional problems
2 and the underwriting would therefore be mainly a tax
3 financial underwriting arrangement.
4 COMMISSIONER FIRESTONE: If I under-
5 stood you correctly, you would visualize the Federal Govern-
6 ment making a financial contribution to a plan that might
7 be Provincially administered and the Provincial Government
8 itself making a contribution?
9 MR. KING: Yes, we would expect that
10 such problems could be solved by our people in the medical
11 and administrative field, and also that our legal frater-
12 nity could solve the medical and surgical problems as they
13 have the hospital one --- the hospital coverage.
14 COMMISSIONER FIRESTONE: Would you then
15 visualize a medical care program that would embody the
16 same principles of financing and organization of the pro-
17 gram as has been adopted in the hospital insurance program?
18 MR. KING: We realize as a Union that
19 these things have to be paid for. We are paying for them
20 at the present time. It might well be that disseminated
21 taxation through the whole population of Canada might have
22 to replace the present methods of payment. We realize
23 these things have to be paid for, but we feel that we can
24 pay for them and should pay for them, because we feel the
25 Canadian people's health is of primary consideration to all
26 Canadians.
27 COMMISSIONER FIRESTONE: You say "We
28 feel that such a plan should be paid for". I feel that is
29 a sensible way of looking at it. Obviously, when you intro-
30 duce certain services, they have to be paid for from some

involve the vesting aside of the constitutional problems and the underwriting would therefore be mainly a tax financial underwriting arrangement.

COMMISSIONER FIRSTCHE: If I understood you correctly, you would visualize the Federal Government making a financial contribution to a plan that might be Provincially administered and the Provincial Governments itself making a contribution?

MR. ETHE: Yes, we would expect that such problems could be solved by our people in the medical and administrative field, and also that our legal fraternity could solve the medical and surgical problems as they have the hospital one --- the hospital coverage.

COMMISSIONER FIRSTCHE: Would you the visualize a medical care program that would embody the same principles of financing and organization of the program as has been adopted in the hospital insurance programs?

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COMMISSIONER FIRSTCHE: You say "We feel that such a plan should be paid for". I feel that is a sensible way of looking at it. Obviously, when you introduce certain services, they have to be paid for from some

source.

Just to consider how this could be done, would you favour this program be paid for through taxation, premiums, or a combination of the two?

MR. KING: I think I would not care to. I have never given a great deal of thought to the methods in which it would be done. I think we have people more competent than I to develop an equitable system that would look after the financing of it.

COMMISSIONER FIRESTONE: Let us assume that the experts will tell us that a system of taxation might be an equitable system. Would your Executive be prepared to recommend to the members of your Union to support higher taxes to pay for such services?

MR. KING: If we were convinced that it was in the national interest, yes. We are not cowards.

COMMISSIONER FIRESTONE: Are you convinced that it is in the interests of Canada to have a comprehensive medical care plan for all Canadians irrespective of individual economic circumstances?

MR. KING: Absolutely.

COMMISSIONER FIRESTONE: Well, this program has to be paid for, and if some of the money may come from taxation and it means higher taxes, would you support such higher taxes in Canada?

MR. KING: If it were necessary to do so, yes.

We feel, though, that the industrial growth and the productive capacity of Canada industrially is such that the costs could be equitably spread.

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COMMISSIONER FIRESTONE: But you are saying that if the only way to introduce such a program is involving increased services for Canadians involved increased cost or were the only way to finance it is some of it through premium payments, some through taxes, and if taxes mean higher rates of taxes, you would recommend such higher rates of taxes?

MR. KING: I did not say that, Commissioner Firestone: I am trying to find out what you mean.

COMMISSIONER FIRESTONE: I did not say it would cost more, really. I said it would be a cost that would have to be faced. It might well be that by the centralization of services and the elimination of many of the insurance plans, that it would not be an increase. There could even be a reduction by a properly organized medical and surgical service. We do not know these things; it is all in the realm of supposition, I suppose.

THE CHAIRMAN: Well, that is admitted. We have not got all the detailed estimates nor the surveys at our disposal to come to any definite conclusions. But, let us assume just for discussion's sake that what your proposal entails is expansion to medical care services to everybody?

MR. KING: Could I just go one step further with that last thought?

COMMISSIONER FIRESTONE: Yes.

MR. KING: If my recollection serves me correctly, I do not feel that we were paying -- as a fortunate group in the CM&S empire -- I do not think we had to pay any more as a result of national hospitalization

COMMISSIONER HIRSTONE: But you are saying that if the only way to introduce such a program is involving increased services for Canadians involved increased cost or were the only way to figure it is some of it through premium payments, some through taxes, and it means higher rates of taxes, you would recommend such higher rates of taxes?

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COMMISSIONER HIRSTONE: I did not say it would cost more, really. I said it would be a cost that would have to be taken. It might well be that by the centralization of services and the elimination of many of the insurance plans, that it would not be an increase. There could even be a reduction by a properly organized medical and surgical service. We do not know those things it is all in the realm of speculation, I suppose.

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MR. LAMB: If my recollection serves me correctly, I do not recall that we were paying -- as a fortunate group in the CNSS empire -- I do not think we had to pay any more as a result of national hospitalization

than we were paying in our own little hospital service prior to that, or when Provincial hospitalization came in. I do not think there was really a great increase in the cost to us, because we were a little island of protection in the Kootenays and many people living in the Kootenays that did not work for CM&S Company and were not covered by Union's bargaining apparatus had no protection.

COMMISSIONER FIRESTONE: What you are saying is that you were better off than the others?

MR. KING: Yes. But all I am saying, too, is that when the Provincial plan came in, I do not recollect any extreme increase in what we were paying for hospital services then, and what we were paying before.

COMMISSIONER McCUTCHEON: What did you pay before?

MR. KING: I forget, but I think it was, $2.75 for a family.

COMMISSIONER McCUTCHEON: A month?

MR. KING: A month.

COMMISSIONER McCUTCHEON: And you now have in this Province an increase of 2% in sales tax, which was declared to be for the purpose of helping the Province make its contribution to hospital insurance. That would be probably more than $2.75 a month?

MR. KING: As a matter of fact, we are still paying for hospital services in our plan at Trail and Kimberley. We are paying 50¢ a month to cover the surcharge for the excess over the regular rate.

THE CHAIRMAN: That is the dollar a day?

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COMMISSIONER MACLUTCHEON: What you are saying is that you were better off than the others?

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THE CHAIRMAN: That is the dollar a

MR.KING: Yes. We pay that on the basis of the 50¢ a month. Every employee pays that. But some years we go three or four months without an assessment, because it is unnecessary. The fund is also administered by these groups I mentioned, and it is a very, very small amount in the aggregate.

COMMISSIONER McCUTCHEON: But you are paying a 2% sales tax in this Province which you were not before?

MR. KING: That is true, but we are paying a lot of extra taxes for a lot of other things we did not pay before, many of which we have far less sympathy with than the hospital services.

COMMISSIONER McCUTCHEON: I understood your suggestion was you probably paid less now than you did before?

MR. KING: I would not want to say that, Mr. Commissioner. I indicated I did not recall there was such a great increase to us after the plan went in.

THE CHAIRMAN: You do not know what you are paying now? I mean, you buy a car and depending on the value of the car -- if it is a $2,000.00 car, you are paying $40.00?

MR. KING: Well, it was a less painless way, I suppose. A less painful way, I should say.

COMMISSIONER FIRESTONE: Just to bring this point to a conclusion, without trying, Mr. King, to assess whether it is going to be a little bit more or a little bit less. You are quite right in saying we really have not got the facts, figures and surveys at our disposal

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THE CHAIRMAN: You do not know what you are paying now? I mean, you buy a car and depending on the value of the car -- if it is a $2,000.00 car, you are paying 5%.

MR. KING: Well, it was a less painful way, I suppose. A less painful way, I should say.

COMMISSIONER FITZPATRICK: Just to bring this point to a conclusion, without trying, Mr. King, to assess whether it is going to be a little bit more or a little bit less. You are quite right in saying we really have not got the facts, figures and surveys at our disposal

to come to any decision arithmetically as to whether it is going to be a little bit more or a little bit less. We must, however, realize that if a comprehensive medical care plan is developed for all Canadians, it will cover people who have not received medical care and someone will have to pay for this. It may conceivably cost somewhat more than we are paying now in national terms, not necessarily for your membership, than we are spending on medical care now.

If it is going to cost more, we have to find ways and means to finance the increased expenditures.

MR. KING: Naturally.

COMMISSIONER FIRESTONE: And if some of it will come out of taxes and general revenue, which is financed from taxes, it may well mean that Governments, before they can introduce such a plan, may have to make the decision whether they can proceed in imposing additional taxes to raise the money.

This is a decision Governments have to make. Now, it would help Governments if they had an expression of opinion from those who ask for these services as to whether they are willing to pay higher taxes -- if it was found necessary to raise taxes -- to get these services on a national basis, on a comprehensive plan such as is recommended.

If I may ask you, would you be prepared to recommend, you and your Executive, to your Union members to say, if we have to pay higher taxes to get those services, we recommend you support such higher taxes. Would you be prepared to do so?

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If it is going to cost more, we have to find ways and means to finance the increased expenditures.

M. ROBB: Assuredly.

COMMISSIONER FERGUSON: And if some of it will come out of taxes and general revenue, which is financed from taxes, it may well mean that Governments, before they can introduce such a plan, may have to make the decision whether they can proceed in imposing additional taxes to raise the money.

This is a decision Governments have to make. Now, it would help Governments if they had an expression of opinion from those who ask for these services as to whether they are willing to pay higher taxes -- if it was found necessary to raise taxes -- to get these services on a national basis, or a comprehensive plan such as is recommended.

If I may ask you, would you be prepared to recommend, you and your Executive, to your Union members to say, if we have to pay higher taxes to get these services, we recommend you support such higher taxes. Would you be prepared to do so?

MR. KING: You really put me on the spot. But I think I would, if I was personally convinced that it was an equitable plan, and that the taxation and payment for it was to be equitably shared by industry and taxation on the people, I believe that our Executive would do so.

COMMISSIONER FIRESTONE: Well, that is a reasonable and realistic answer, sir. Thank you very much.

THE CHAIRMAN: Thank you very much, Mr. King.

MR. KING: Thank you.

THE CHAIRMAN: The British Columbia Cancer Foundation.

---EXHIBIT NO. 179: Submission of the British Columbia Cancer Foundation.

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THE CHAIRMAN: Thank you very much.

MR. KING: Thank you.

THE CHAIRMAN: The British Columbia

---EXHIBIT No. 172: Submission of the British

SUBMISSION OF

THE BRITISH COLUMBIA CANCER FOUNDATION

APPEARANCES:

MR. J. M. WARREN

MR. G. S. CLARK

DR. A. MAXWELL EVANS

MR. CLARK: I am appearing in lieu of Mr. Blair, and my name is Clark, C-L-A-R-K. The initials are G. for George, and S. for Savage. That is my real name, I may say, Mr. Chairman.

I am appearing in my capacity of Vice-President of the Foundation in the absence of the President, Mr. Blair, who is unavoidably not available.

I have with me Dr. A. Maxwell Evans, who is Medical Director of the Foundation, as well as being director of its cancer clinic, who will present our brief. I am also accompanied by Mr. Jack M. Warren, the administrator the Foundation's cancer clinic who is available to answer questions relating to the operation, and the mechanics of the undertaking.

DR. EVANS: RECOMMENDATIONS

It is recommended that the British Columbia Cancer Foundation carry on its programme as at present and expand its services as occasion demands. The method of financing is sound and should continue.

It is recommended that a greater effort be made to encourage young Canadian doctors to enter the specialty of radiotherapy. This also involves a realistic approach to financial remuneration.

S U B M I S S I O N O F

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It is recommended that a greater effort be made to encourage young Canadian doctors to enter the specialty of radiotherapy. This also involves a realistic approach to

It is recommended that a cancer registry be established at the British Columbia Cancer Institute so that accurate incidence studies of cancer in British Columbia can be determined.

It is recommended that a study be undertaken to ascertain the bed requirements for patients suffering from malignant disease.

Of course, there is no easy solution to this, as you probably well know, but I do believe that when this regional Metropolitan Planning Hospital, I think it is called, does bring in its final recommendations I hope it brings in recommendations concerning the use and availability of beds for chronic cancer patients as opposed to acute care patients. I imagine this is quite a common occurrence across Canada that chronic patients are taking up beds in general hospitals which should be used for acute care. This is a summary of the activity of the Foundation and a few recommendations.

THE CHAIRMAN: Thank you. Dr.Baltzan?

COMMISSIONER BALTZAN: I have just a few things to help me clear up some things in my own mind. Number 8 on page 3, you refer to "radiotherapy, by chemotherapy and by hormone therapy." Is there any provision for surgery?

DR. EVANS: It is referred to somewhere in the brief that the British Columbia Cancer Foundation takes no responsibility whatever for surgical treatments. Yes, it is on page 4 and it says:

"Surgical treatment is carried out in general hospitals in British Columbia and is not under

It is recommended that a cancer registry be established at the British Columbia Cancer Institute so that accurate incidence studies of cancer in British Columbia can be

It is recommended that a study be undertaken to ascertain the bed requirements for patients suffering from malignant disease.

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COMMISSIONER BANTMAN: I have just a few things to help me clear up some things in my own mind. Number 6 on page 3, you refer to "radiotherapy, by chemotherapy and by hormone therapy." Is there any provision for surgery?

R. EVANS: It is referred to somewhere in the brief that the British Columbia Cancer Foundation

Yes, it is on page 4 and it says:

"Surgical treatment is carried out in general hospitals in British Columbia and is not under

the aegis of the British Columbia Cancer Foundation."

COMMISSIONER BALTZAN: In that connection let us turn to page 9, Paragraph B at the top of the page:

"All patients admitted to the British Columbia Cancer Institute are interviewed by a social worker who assesses the patient's ability to pay for services."

Question number one; what happens if they are unable to pay?

DR. EVANS: They get the service and the cost of giving the service is made up by the Federal-Provincial Cancer Grant.

COMMISSIONER BALTZAN: I see.

THE CHAIRMAN: They are put in a category of non-pay at the time?

DR. EVANS: That is right.

COMMISSIONER BALTZAN: When you judge them as unable to pay, do you use something in the way of, shall we use that word, a means of finding out?

DR. EVANS: May I throw this over to Mr. Warren.

MR. WARREN: When patients are admitted to the Institute one of the first procedures is that they are interviewed by trained and qualified social workers. The purpose of this interview is to determine the patient's resources so that there are certain assistances that are available to patients. We also do this so that we want to get the financial picture in all aspects and the management of the case. This time the social worker goes into, if necessary, a fairly complete review of the patient's

COMMISSIONER BALTZAN: In the 1 commission let us turn to page 9, Paragraph B at the top of the page.

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DR. E. MES: That is right.

Then as unable to pay, do you use something in the way of, shall we use that word, a means of trying out?

DR. EVANS: May I turn this over to Mr. Wadman.

MR. WADMAN: When patients are admitted to the Institute one of the first procedures is that they [illegible]

The purpose of this interview is to determine the patient's resources so that terms are certain assistances that are available to patients. We also do this so that we work to get the financial picture in all cases and the management of the case. This time the social worker [illegible]

finances and through this she, by a predetermined scale, assesses the patient as to whether they should be expected to pay or not. We have sort of a base scale that we work to and this is adjusted to take into account all extenuating circumstances. A patient's professional diagnosis has a bearing on this and what ultimate cost they might run into. This is all gone into rather thoroughly and the ultimate objective is that no patient should find it a financial hardship to be extended the services of our Institute.

COMMISSIONER BALTZAN: Do you find any difficulty in getting that kind of information? Do people resent it?

MR. WARREN: No, I think when they understand the reason that the information is asked, we explain to them that we ask this information to help them because there are other sources of assistance available to the patient for transportation through other sources, for medications and drugs and so on. When we explain it to them that we must have a reasonable idea of their finances in order to be able to give them or make them eligible for some of these other things, we do not usually run into any problems of patients resenting a scrutiny of their financial position.

COMMISSIONER BALTZAN: So long as one does not use the word "means" test.

MR. WARREN: We do not use it.

COMMISSIONER BALTZAN: In your medical staff in the Cancer Institute you employ four radiotherapists?

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COMMISSIONER FAIRMAN: So long as one does not use the word "means" test.

MR. WARREN: We do not use it.

COMMISSIONER FAIRMAN: In your medical staff in the Cancer Institute you employ four radiotherapists?

DR. EVANS: Five altogether.

COMMISSIONER BALTZAN: That is in your Cancer Institute. Now, does that apply to Victoria?

DR. EVANS: No, Victoria has one radiotherapist.

COMMISSIONER BALTZAN: Employed by the Foundation?

DR. EVANS: Employed ostensibly by the Foundation.

COMMISSIONER BALTZAN: And when you need a consultation you call on a medical staff from the various departments?

DR. EVANS: Yes.

COMMISSIONER BALTZAN: And I notice here they are rendered on a voluntary basis.

DR. EVANS: Yes. This is a minor point regarding that last question of yours; when the patient is admitted as a new patient on the first occasion he is charged a $15.00 consultation fee. In the case of the patients who can pay that fee, roughly half of it goes to the attending medical staff and they put it in the fund; the other half goes to the Cancer Institute and the attending staff uses this money for the purposes of anything they like. They do not divide this money up and put it in their pockets but use it for the benefit of the Institute. They derive no financial benefit whatsoever, not even in subsequent consultation.

COMMISSIONER BALTZAN: But the cost of the diagnosis, the service to the people, that money goes back for these cancer people?

DR. EVANS: Have altogether.

COMMISSIONER BAITZAN: That is in your Cancer Institute. Now, does that apply to Victoria?

DR. EVANS: No, Victoria has one radiotherapist.

COMMISSIONER BAITZ

foundation?

DR. EVANS: Employed officially by the Foundation.

COMMISSIONER BAITZAN: And when you need a consultation you call on a medical staff from the

COMMISSIONER BAITZAN: And I notice here they are mentioned on a voluntary basis.

DR. EVANS: Yes. This is a minor point regarding that very question of yours; when the patient is admitted as a new patient on the first occasion he is charged a $10.00 consultation fee. In the case of the patients who can pay that fee, roughly half of it goes to the attending medical staff and they put it in the fund; the other half goes to the Cancer Institute and the attending staff uses this money for the purposes of anything they like. They do not divide this money up and put it in their pockets but use it for the benefit of the Institute. They derive no financial benefit whatsoever, not even in subsequent consultation.

COMMISSIONER BAITZAN: But the cost of the diagnosis, the service to the people, that money goes back for these cancer people?

DR. EVANS: That is right.

COMMISSIONER GIRARD: Mr. Clark, in your recommendations, number 3, you say:

"It is recommended that a cancer registry be established at the British Columbia Cancer Institute so that accurate incidence studies of cancer in British Columbia can be determined."

Is this simply a statistical compilation or is this to be used for research purposes or what kind of registry would it be?

DR. EVANS: I think every province in Canada, I think nationally we should know the incidence of cancer. That is what I am talking about here and what other people are talking about. Cancer incidence is the number of new patients that appear per year in 1,000,000 population.

COMMISSIONER GIRARD: Purely statistical?

DR. EVANS: These are figures but you have to collect material and collect it from doctors, you have to get a doctor to fill out a form, you have got a record of biopsy reports in the hospital.

COMMISSIONER GIRARD: A central compilation?

DR. EVANS: Yes, all sources to get your information.

THE CHAIRMAN: Going back to that statement at the top of page 4 to which Dr. Baltzan made reference that a surgical treatment is carried out in general hospitals and is not under the aegis of the British Columbia Cancer Foundation, does that mean that the patient pays for

DR. EVANS: That is right.

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THE CHAIRMAN: Going back to that statement at the top of page 4 to which Dr. Baltzan made reference that a surgical treatment is carried out in general hospitals and is not under the auspices of the British Columbia Cancer Foundation, does that mean that the patient pays for

his own surgery?

DR. EVANS: He pays a surgical fee if he can.

THE CHAIRMAN: It is his responsibility. He may have M.S.I. or be covered in various ways but it is an individual responsibility?

DR. EVANS: That is right.

THE CHAIRMAN: There is at least one province in which the whole cost is paid, they have not got that system here in British Columbia?

DR. EVANS: No, sir.

COMMISSIONER VAN WART: Turning to page 9, number 33 following your financial statement you make the statement:

"The deficit in operations is met by the Federal Provincial Cancer Grant."

Is that unlimited or what do you mean by that?

DR. EVANS: It is limited, it is a pro rata cancer grant that the Federal Government put into operation in 1949. Provided the Provincial Government pays up dollar for dollar you get the money.

THE CHAIRMAN: You have an apparent deficit of about $470,000.00.

DR. EVANS: That is right.

THE CHAIRMAN: And that has all been recovered?

DR. EVANS: In the past it has all been recovered through this cancer grant.

COMMISSIONER VAN WART: If you had a

MR. EVANS: He pays a surplus fee if he can.

THE CHAIRMAN: It is his responsibility. He may have M.S.I. or be covered in various ways but it is an individual responsibility?

MR. EVANS: That is right.

THE CHAIRMAN: There is at least one province in which the whole cost is paid, they have not got that system here in British Columbia.

MR. EVANS: No, sir.

COMMISSIONER VAN WART: Turning to page 5, number 33 following your financial statement you make the statement:

"The deficit in operations is met by the Federal Provincial Cancer Board."

Is that intended or what do you mean by that?

MR. EVANS: It is limited, it is a pure rate cancer grant that the Federal Government put into operation in 1949. Provided the Provincial Government pays up dollars for dollars you get the money.

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MR. EVANS: In the past it has all

COMMISSIONER VAN WART: If you had a

deficit up to a million dollars would it be recovered eventually?

DR. EVANS: Not at the moment.

COMMISSIONER VAN WART: You are limited to what you can recover?

DR. EVANS: At the moment, yes.

THE CHAIRMAN: What is the limit?

DR. EVANS: It is roughly about $630,000.00. We estimate that, we do not know what it is, we estimate it.

MR. CLARK: Perhaps it might throw a little light on things if I explained that the budget is submitted to the Provincial Government and we must contrive to work within that budget. There is no unlimited ceiling on the funds available to us.

COMMISSIONER VAN WART: Then, turning to Appendix A, if you notice at the top the date of the article is 1947 and that is fifteen years ago, but you are still quoting from it "necessity for centralization of radiotherapy". Is that still the thought or has that been countermanded in the last fifteen years?

DR. EVANS: Mr. Chairman, this idea of centralization has been the basis of operations of the Cancer Foundation. As a matter of interest we did write, I did write about a year ago to Dr.Paterson in Manchester to ask him whether he had changed in the intervening years his opinion as expressed in this article. The only thing he had changed was a problem that does not concern us and that was the surgery problem; he had changed his idea as to how surgical cancer should be treated. In other words,

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DR. EVANS: Not at the moment.

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DR. EVANS: It is roughly about $650,000.00. We estimate that, we do not know what it is, we estimate it.

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in 1947 he was thinking in terms of cancer hospitals where all forms of treatment should be given in this hospital and now he believes that the surgical treatment of cancer should be by the various specialties like thorasic surgery, general surgery, urological surgery and that sort of thing, and not in a special cancer hospital. Basically we feel this is still sound even after fifteen years. And may I comment on one aspect of this report in the sense that the Foundation itself does not operate and I refer to cytology in paragraph 34.

The Foundation provides space for the operation of the cytology lab and it is operated by the Director of the Department of Pathology of the General Hospital. It think it is quite a unique laboratory in the sense as indicated in the brief we have reduced the incidence of clinically invasive cancer of the cervix in British Columbia. If this was a national program it would really be a great step forward in the reduction of invasive cancer of the cervix. I would commend this as a worthwhile consideration, as preventive medicine, actually.

COMMISSIONER VAN WART: One more question, according to your recommendations, recommendation number 2, you are speaking about Canadian doctors entering the specialty of radiology then you state this also involves a realistic approach to financial remuneration. Can you explain what you had in mind?

DR. EVANS: I think improving some of the resistance of medical graduates, particularly when they are interning, they have a resistance about going into radiotherapy because the salaries may not be adequate,

In 1947 he was teaching in Rome at cancer hospitals where all forms of treatment could be given in this hospital and now he believes that the surgical treatment of cancer should be by the various specialties like thoracic surgery, general surgery, urological surgery and that sort of thing and not in a special cancer hospital. Basically we feel

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COMMISSIONER MARTIN: One more question. According to your recommendations, recommendation number 2, you are speaking about cytology doctors covering the specialty of pathology then you share this also involves a realistic approach to financial remuneration. Can you explain what you had in mind?

DR. EVANS: I think implicating some of the assistance of medical graduates, particularly when

are not adequate. I think if we are going to induce young doctors to take up the specialty of radiotherapy, this will be a condition that will have to be looked into quite seriously and met to insure we get enough in.

COMMISSIONER McCUTCHEON: What is the salary level generally?

DR. EVANS: The salary level, I think, across Canada in radiotherapy centres should be uniform so there is no rate competition from one institution to another. I know for a fact there are some places where they are just having a terrible time because salaries are too low. I don't think they have anybody at all. We have to be realistic.

COMMISSIONER McCUTCHEON: Are your salary levels in B.C. lower than elsewhere?

DR. EVANS: Well, in our own place, the Cancer Institute, we are in the process of negotiating and doing our best to get these up to what we call a reasonable level. They are a little lower than they are in Ontario and Manitoba.

COMMISSIONER VAN WART: Would it be a fair assumption that the reimbursement of radiologists in the diagnostic field is much greater than in the therapeutic field?

DR. EVANS: Absolutely, quite true.

COMMISSIONER VAN WART: That is the reason why they are not taking up therapy. Is that a reasonable assumption?

DR. EVANS: I think that is a very reasonable assumption, yes.

young doctors to take up the specialty of radiotherapy, but will be a condition that will have to be looked into quite seriously and met to insure we get enough in.

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COMMISSIONER MCINNES: Would it be a fair assumption that the maldistribution of radiologists in the diagnostic field is much greater than in the therapeutic field?

COMMISSIONER VAN WART: That is the reason why they are not taking on therapy. Is that a

reasonable assumption, yes.

COMMISSIONER McCUTCHEON: Is the answer because one is fee for service and the other is a salary basis?

DR. EVANS: Probably, I don't know. I couldn't really answer that. I would suspect that is probably the answer.

COMMISSIONER McCUTCHEON: But it is true, isn't it, Doctor, that salaried radiologists, salaried diagnostic radiologists are paid considerably higher than radiotherapists?

DR. EVANS: That is correct.

THE CHAIRMAN: Going to the Cytology, Item 34 on page 9, that is paid for, carried by the Vancouver General Hospital and you say financed by Federal, Provincial Cancer Grants. Are these special cancer grants additional to or carried as part of the operation of that hospital?

DR. EVANS: That is part of the $630,000.00 that is available from the Federal, Provincial Cancer Grant.

THE CHAIRMAN: It takes roughly $100,000.00 to operate that department?

DR. EVANS: That is right.

THE CHAIRMAN: Is there sufficient money, reasonably sufficient money for the time being for the work?

DR. EVANS: For the time being, I think there is, yes, but I may say this, this may help to clarify the situation, as seen at the moment regarding Pappenheim smears, we should do a yearly smear on all women over 20.

because one is fee for service and the other is a salary

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DR. EVANS: For the time being, I think there is,yes, but I may say this, this may help to clarify the situation, as seen at the moment regarding Preventive measures, we should do a yearly smear on all women over 20.

In this population there are 400,000 women. It is not anticipated you could screen all women. Now, what we have done, we do 100,000 now. If this goes any higher with further intensive publicity then I think this program will cost some money.

THE CHAIRMAN: Should there be more than one laboratory?

DR. EVANS: For this population, I wouldn't think so.

COMMISSIONER BALTZAN: How often should these tests be made?

DR. EVANS: At least once a year.

COMMISSIONER FIRESTONE: Could you provide increased services if your cancer grants were raised by 20% that you would feel would serve the cancer sufferers of British Columbia?

DR. EVANS: I am sorry, I didn't quite understand the question.

COMMISSIONER FIRESTONE: You have financial grants from the Federal, Provincial Government.

DR. EVANS: Yes.

COMMISSIONER FIRESTONE: If that grant was raised by 20%, could you provide increased services to cancer sufferers?

DR. EVANS: No, I think actually at the moment we have adequate services to provide.

COMMISSIONER FIRESTONE: Adequate funds to pay for these services?

DR. EVANS: We are getting very close to the breaking point, but at the moment I think it is adequate.

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COMMISSIONER MACKEAN: How often should these tests be made?

DR. EVANS: At least once a year.

COMMISSIONER MACKENZIE: Could you provide increased services if your cancer grants were matched by 50% since you would feel would serve the cancer sufferers of British Columbia?

DR. EVANS: I am sorry, I didn't quite understand the question.

[illegible]

DR. EVANS: Yes.

COMMISSIONER MACKENZIE: If that grant was matched by 50%, could you provide increased services to cancer sufferers?

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COMMISSIONER MACKENZIE: Adequate funds to pay for these services?

DR. EVANS: We are getting very close to the boundary point, but at the moment I think it is adequate.

COMMISSIONER FIRESTONE: You appreciate, sir, this Commission has been asked to recommend to the Government a program that will take care of a future period of time, therefore, have you any recommendations to offer to this Commission as to how your future needs could be taken care of?

DR. EVANS: Well, if the cancer grant itself is not increased we will have to get the money to operate from some other source.

COMMISSIONER FIRESTONE: My reference is to the cancer grant. Would you suggest that this grant at the moment is adequate, that you expect your institutions will require and you will require an increased amount?

DR. EVANS: Yes, I think that is true.

COMMISSIONER FIRESTONE: Have you any suggestions to offer as a guide to the Provincial, Federal Governments as to how the cancer grant should be increased. Have you any suggestions to offer us on the increased funds necessary as the services increases with growing population and growing service?

DR. EVANS: The only way I could think is increased pro rata grants. Mr. Warren and I were trying to figure out the other day what it is and it is roughly 20¢ per person.

MR. WARREN: It is approximately.

DR. EVANS: The only way I could think of would be to increase that.

THE CHAIRMAN: Doctor Evans, why is not the cost of this laboratory dealt with as part of the operating cost of the Vancouver General Hospital?

COMMISSIONER FIRESTONE: You appreciate, sir, this Commission has been asked to recommend to the Government a [illegible] that will take care of a future period of time, therefore, have you any recommendations to offer to this Commission as to how your future needs could be taken care of?

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DR. EVANS: Yes, I think that is true.

COMMISSIONER FIRESTONE: Have you any suggestions to offer as a guide to the Provincial,Federal Governments as to how the cancer grant should be increased? Have you any suggestions to offer us on the increased funds necessary as the services increase with growing population and growing services?

DR. EVANS: The only way I could think is increased per capita grants. Mr. Norman and I were trying to figure out the other day that it is and it is roughly 40¢ per year.

MR. NORMAN: It is considerable.

DR. EVANS: The only way I could think of would be to increase that.

THE CHAIRMAN: Doctor Evans, why is not the cost of this laboratory dealt with as part of the operating cost of the Vancouver General Hospital?

DR. EVANS: As an in-patient service?

THE CHAIRMAN: As is done in some other provinces, and therefore if that is done your Council would have $100,000.00 for some other area.

DR. EVANS: That is quite right.

MR. WARREN: It is not primarily an in-patient service.

DR. EVANS: This service covers the whole province. Doctors from all over the province send their material here.

THE CHAIRMAN: Send the patient?

DR. EVANS: No, the slide. It is not a service that is confined to the General Hospital. In fact, I can't tell you what percentage would come from the General Hospital, but it is quite small. Out of the total number of slides that are sent in from doctors of the province the percentage from the hospital, I think is quite small.

THE CHAIRMAN: It might be a matter of inter-hospital accounting.

DR. EVANS: It started out as a research project about ten years ago and grew gradually. After it started out as a research project and the money was donated by the Canadian Cancer Society and it was through this the technicians were trained. The basic thing about this program is you have to have enough technicians to do the screening of the slides and the pathologist only has to look at a few. It had to overcome a good deal of opposition in a way, in a sense, here was a free service being done for the whole province and whether that had any

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influence on the way it is now financed I don't know. Perhaps it did. I am sure it is a first-class service.

THE CHAIRMAN: In any event, it is operating.

DR. EVANS: It is doing a wonderful job.

THE CHAIRMAN: A wonderful job.

DR. EVANS: No question about it. The Director of the Department deserves a great deal of credit.

COMMISSIONER BALTZAN: Is there a Provincial laboratory doing any analysis of test, urology tests and others?

DR. EVANS: No Provincial laboratory as yet.

COMMISSIONER BALTZAN: If you had one these things could be transferred there except for what you use in research investigation.

DR. EVANS: No, each hospital has a pathologists that acts as his own unit. There is no hospital in which a lab such as this exists.

COMMISSIONER VAN WART: Mr. Chairman, your costs for diagnostic services, plus your costs for your radiotherapy and so on plus surgical costs for cancer patients is not the greatest cost in the treatment of cancer patients, it is after that, that is where the custodial care of the sickness and the caring for the patient after they go through surgery, that is the greatest cost in the cancer program, is it not, to the patient or to whoever is paying the bill?

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COMMISSIONER BARTHAM: Is there a Provincial laboratory doing any analysis of tissue, medical tests and others?

DR. EVANS: No Provincial laboratory as yet.

COMMISSIONER BARTHAM: If you had one these things could be transferred there except for what you use in research investigation.

DR. EVANS: No, ever hospital has a pathologists that acts as his own staff. There is no hospital in which a lab such as this exists.

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DR. EVANS: I really don't know. I

1 couldn't answer that. If you assume that you cure
2 50% of patients which means at the end of five years 50%
3 are still alive.
4 COMMISSIONER VAN WART: It is the
5 other 50, their cost goes up.
6 DR. EVANS: You are talking about the
7 patient in the terminal stage of the disease.
8 COMMISSIONER VAN WART: After you are
9 through the stages of diagnosing and your major treatment
10 procedure, after that, that is where the ultimate cost is
11 so heavy to the patient or to somebody, custodial care.
12 DR. EVANS: I suppose it would be.
13 COMMISSIONER McCUTCHEON: Could I ask
14 one question. Reference is made to the income from patients
15 and to your screening. Is your Institution not an improved
16 hospital under the Hospital Act?
17 DR. EVANS: The British Columbia Act,
18 it is not a hospital as such.
19 COMMISSIONER McCUTCHEON: It is not
20 regarded as a hospital for the purposes of the plan?
21 MR. WARREN: No.
22 COMMISSIONER McCUTCHEON: You get no
23 remuneration for your in-patients?
24 DR. EVANS: Not at the moment. We are
25 working toward it. We are presently negotiating with them
26 about this very matter. At the moment, no.
27 COMMISSIONER McCUTCHEON: If, of course,
28 you receive that payment for your in-patients that would
29 make the grant go that much further.
30 DR. CLARK: We are struggling toward

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DR. EVANS: I suppose it would be.

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THE CHAIRMAN: Thank you very much Dr. Clark and Dr. Evans. We are very grateful to you for your help this afternoon.

DR. CLARK: Thank you, Mr. Chairman, and members of the Commission.

THE CHAIRMAN: Now, we will have the Cerebral Palsy Association of British Columbia and the Cerebral Palsy Association of Greater Vancouver.

THE SECRETARY: They will be Exhibits 180 and 181, sir.

---EXHIBIT NO. 180: Submission of the Cerebral Palsy Association of British Columbia.

---EXHIBIT NO. 181: Submission of the Cerebral Palsy Association of Greater Vancouver.

APPEARANCES:

MR. E.G. ROLSTONE

MR. E. CAMPBELL

MR. W. BROWN

DR. H.G. DUNN

MRS. G. LAMONT

MR. ROLSTONE: Mr. Chairman and gentlemen, I am here in my capacity as President of the British Columbia Cerebral Palsy Association. I have with me Dr. Dunn who is our medical advisor, Chairman of the Medical Advisory Committee of our Association and Mrs. George Lamont who is our Executive Secretary. On my extreme

THE CHAIRMAN: Thank you very much Dr. Clark and Dr. Evans. We are very grateful to you for your [illegible].

DR. CLARK: Thank you, Mr. Chairman, and members of the Commission.

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MR. MORRISON: Mr. Chairman and gentlemen, I am here in my capacity as President of the British Columbia Cerebral Palsy Association. I have with me Dr. Dunn who is our medical advisor, Chairman of the Medical Advisory Committee of our Association and Mrs. George Lemont who is our Executive Secretary. On my extreme

right, Mr. Wyndham O'Brien who is Secretary of the Vancouver Cerebral Palsy Association and Mr. Earl Campbell who is President of the Greater Vancouver Cerebral Palsy Association. Dr. Dunn will present the brief on behalf of the B.C. Cerebral Palsy Association.

THE CHAIRMAN: Dr. Dunn.

DR. DUNN: In this Brief the health services for persons with cerebral palsy in British Columbia are reviewed. It is pointed out that cerebral palsy comprises a group of complex conditions in which a brain defect interferes with voluntary movement and even with the normal resting tension of muscles. Owing to the complexity of the condition, sufferers from cerebral palsy require assessment and treatment by a variety of medical specialists as well as ancillary para-medical personnel and representatives of other disciplines, such as special education and social work. This condition may serve as a good example of a chronic disability which is liable to impose a permanent handicap in relation to physical and mental health.

The main conclusions are as follows:

The Cerebral Palsy Associations, special clinics, and other services have been largely established by the parents and other voluntary groups. As the programme has expanded it has become increasingly difficult to finance it adequately and to initiate extensions which are essential to comprehensive care; therefore increasing financial support from the community and from government at its various levels is required.

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given to children with cerebral palsy have to be followed by further social service, vocational guidance and job placement if the total mental and physical health of the persons concerned is to be maintained at its optimal level. Earlier case finding is desirable for optimal management; this will require more education of the public and of the medical and nursing professions in relation to cerebral palsy.

In the use and planning of services for persons with cerebral palsy there is room for increased cooperation between clinics and other facilities established by the Cerebral Palsy Associations and -

government organizations, such as public health and welfare agencies, special placement officers of the National Employment Service, and special education departments of public schools.

other voluntary organizations assisting the handicapped, particularly those with related disorders, such as epilepsy and mental retardation which frequently accompany cerebral palsy.

The required expansion of services for persons with cerebral palsy and allied handicaps will also necessitate the training of further specialized personnel, not only among physicians (e.g. paediatric neurologists, specialists in physical medicine, child psychiatrists), but also particularly among ancillary staff, such as psychologists, physiotherapists, social workers, speech therapists and occupational therapists.

The following recommendations are therefore made:

Financial support from government sources to cerebral

n to children with cerebral palsy have to be followed by further social service, vocational guidance and job placement if the total mental and physical health of the persons concerned is to be maintained at the optimal level. Earlier case finding is desirable for optimal management; this will require more education of the public and of the medical and nursing professions in relation to cerebral palsy.

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The required expansion of services for persons with cerebral palsy and allied handicaps will also necessitate the training of further specialized personnel, not only among physicians (e.g. pediatric neurologists, specialists in physical medicine, child psychiatrists), but also particularly among sanitary staff, such as psychologists, physiotherapists, social workers, speech therapists and occupational therapists.

Financial support from government sources to cerebral

palsy associations and particularly their treatment centres should be extended. Hospital insurance should be made increasingly available for in-patient care of persons with chronic disabilities. This insurance should also be extended to cover ambulatory care which is the most usual and economic form of management. Alternatively, the present system whereby salaries of physiotherapists and other specialized staff at treatment centres may be covered from National Health Grants, should be widened to encompass administrative and clerical staff and also field representatives visiting patients, assisting local parent groups and educating the public in health matters.

As the cerebral palsied are particularly prone to dental defects, the inclusion of a comprehensive dental care programme in any proposed Health Insurance plan is of utmost importance. Provision for free dental care (including conservative dentistry) is particularly urgent for those cerebral palsied receiving disability pensions.

Government assistance (both federal and provincial) should be provided in relation to the capital cost of construction of further small centres (or fringe clinics) for children with cerebral palsy and similar handicapping disorders at strategic points in the Province.

Government authorities (both federal and provincial) should assist in the establishment of training centres where handicapped persons may receive vocational guidance and specific instruction so as to learn jobs which they can subsequently perform in accordance with the needs of

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Government authorities (both federal and provincial) should assist in the establishment of training centres where handicapped persons may receive vocational guidance and specific instruction so as to learn jobs which they can subsequently perform in accordance with the needs of

industry. Provision should be made to give financial aid to the cerebral palsied undertaking vocational training. For those who cannot function in the community on a competitive level, the establishment of sheltered workshops also requires government support.

The treatment centres will have to be increasingly concerned with the role of social problems in relation to the total health of the patients and particularly with vocational guidance and occupational training. In this regard there is a greater need for field services by staff qualified in nursing, social work and/or physiotherapy and also by travelling medical teams. In these follow-up services the cooperation of the public health services is vitally necessary. The Registry for Handicapped Persons should also be utilized in follow-up and in the compilation of statistics.

To train more specialized personnel, facilities such as the School of Rehabilitation at the University of British Columbia will have to be extended. Financial incentive, such as special scholarships, should be provided to attract suitable persons into this field of care for persons with neurological disorders.

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MR. BROWN: The Cerebral Palsy Association of Greater Vancouver proposes to present only the summary.

SUMMARY:

The Cerebral Palsy Association of Greater Vancouver in general supports the brief submitted by the Cerebral Palsy Association of British Columbia but particularly

RECOMMENDS:

(i) an increase of government leadership and co-ordination in the field of service to the handicapped.

(ii) an increase in government financial support.

(iii) greater clarity and earlier and longer term financial decisions by the government on the amounts of such financial support.

(iv) close consideration by the government of the specific ways in which financial support can best be rendered so as to provide stimulation to agency programmes.

(v) the continuance of the vital role of the voluntary agency with a clear recognition by the government of this role.

THE CHAIRMAN: Thank you.

Now, is there anyone in the group who wishes to add anything further to what has been said by way of amplification or expansion?

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SUMMARY:

The General Relay Association of Greater Vancouver in general supports the brief submitted by the General Relay Association of Western Canada but particularly

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THE CHAIRMAN: Thank you.

Now, is there anyone in the group who wishes to add anything further to what has been said by way of amplification or expansion?

MR. ROLSTONE: No, sir.

COMMISSIONER VAN WART: Mr. Chairman, in reading over the British Columbia brief, which is specific in asking for, as I note, four different types of Federal aid; first of all, on page 2, number 1, you ask financial support be given to the treatment centres.

Well, that is centres where the disease itself is being treated; the patient is treated. Are you visualizing that in the present outdoor hospitals, or what is your idea visualized there?

DR. DUNN: Sir, I am not quite with you.

COMMISSIONER VAN WART: Page 2, number 1.

DR. DUNN: The bottom paragraph?

COMMISSIONER VAN WART: Yes.

DR. DUNN: At present, the Federal Government channels funds to the treatment centres through the Provincial Association -- for instance, for the salary of physiotherapists. And these are of some considerable help in the financing and maybe the gentlemen on my left can implement this further, but the overall financial position of all our treatment centres, as far as we can see, in British Columbia is constantly a precarious one. They are always in the position of wishing to increase their services, to get themselves a psychologist, physiotherapist, or a social worker, and they find themselves in the position of not having enough money for this. There is a great need for further financial assistance.

COMMISSIONER VAN WART: On page 3,

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COMMISSIONER VAN WART: On page 3,

number 3, you ask for Government assistance to what you call the fringe clinics, or small centres.

Are they associated with your treatment centres, or are they to be separate clinics?

DR. DUNN: This is the point which has been of much interest to us. The medical advisory committee of the British Columbia Cerebral Palsy Association, which is presently under my chairmanship, and was previously under that of Dr. McCreary, our Dean of Medicine, about five years ago surveyed the treatment facilities in British Columbia. We found that there was a considerable concentration of treatment, particularly in the greater Vancouver clinic, and quite a few children were coming from fairly far afield for regular treatment. Particularly in the Lower Fraser Valley, the most rapidly expanding population at the present time is across the Fraser River in the Surrey area, and I was asked to chair a special committee to investigate as to whether the clinic might be constructed locally to see whether the children could be served there rather than taking a long trip into Vancouver every day. This was investigated, and after a lot of discussion with all the authorities concerned, we decided the best location for such a clinic would be at the Surrey Memorial Hospital, which at that time was not built, but was planned.

The question arose how this clinic should be manned with specialists, and what we envisaged was that initially the clinic should be inclose association with the Greater Vancouver Clinic. The children should be assessed in Vancouver. We had a program for treatment mapped out for a panel, and then they would receive treatment

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and special schooling from the local clinic, and after would come back to Vancouver for a review of progress.

We thought when this had been going on for a few years, the Surrey Clinic might obtain a Dominion constitution and might then assemble its own staff, and finally run itself, but originally it should be run from the Greater Vancouver Centre.

COMMISSIONER VAN WART: And the first thing you asked for in Federal funds is the establishment of training centres. What do you mean by that? Are they schools, or --- ?

DR. DUNN: We feel that ---

COMMISSIONER VAN WART: Number 4.

DR. DUNN: Number 4, yes.

We feel that the greatest challenge in this whole field, the greatest unmet need, is the provision of vocational training and jobs for these patients; for these people.

Whilst a lot of improvement might yet occur in their medical and educational management whilst they are children, the greatest gap and the greatest need, we feel, is that when these patients reach adult life, when they get towards the end of their teens, they are liable then to sit at home and have no job. After having had this physiotherapy and schooling, and other treatment, in the centres, they are liable to end up without a job, a burden to their families and to themselves, and they may sit at home without work.

We, therefore, feel that the provision of vocational guidance and then job placement is a very

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We, therefore, feel that the provision of vocational guidance and then job placement is a very

important and urgent need. This is something which is expensive, and where we feel there is a great need for Government help.

Now, at present, I think it is fair to say that the vocational facilities provided by the Government, such as the vocational institute right here in Vancouver -- a very fine institution -- is not geared towards the training of handicapped persons, whether cerebral palsied or retarded, or various other handicapped as well, and that special new facilities are needed to train these people for jobs they can do.

What some of us have in mind is that the Government might establish special training centres for handicapped persons, where there is relatively light equipment in which the whole course of training would be geared towards vacancies known to exist in industry, and then they would be trained with fairly light mobile equipment in short courses for particular jobs for which there are vacancies available.

COMMISSIONER VAN WART: Carrying on the next item, you ask for Federal funds for sheltered workshops. Would you explain?

DR. DUNN: When the training centres, which we have discussed, are established in the ideal stage, there will probably be a number of persons with such disabilities as cerebral palsy who cannot find a job on a competitive level in industry or agriculture. We envisage this residue who cannot compete on the open market should still be employed in useful work both for the community and their own self-esteem and general health. It

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will be necessary for some of them to be employed in a sheltered setting in workshops which are organized by voluntary services, with Government help.

COMMISSIONER VAN WART: Perhaps in which the trainees would be accepted?

DR. DUNN: To spend probably many years producing the most useful things which they can make within their limitations, and thereby helping the community as well as themselves.

No doubt these sheltered workshops would be expected to have a deficit which would have to be shouldered by the community.

COMMISSIONER VAN WART: The fifth item, you ask for Federal funds to train specialist personnel facilities, such as the school of rehabilitation at the University of British Columbia which will have to be extended. That is your fifth item. Now, as to priority, you would start at the, first of all, the diagnostic clinics, and then the treatment centre. They would have the greatest priority; would they not?

DR. DUNN: Yes, but also the vocational guidance.

COMMISSIONER VAN WART: And the plan would develop up through these stages we have mentioned? Is that your idea of the progress that should be made?

DR. DUNN: Well, we have not really tried to give these points in order of importance. We have not worked it out like that.

I have gone through the different stages through which a child would pass in the treatment of

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DR. DUNN: Yes, but also the vocations guidance.

COMMISSIONER VAN WART: And the plan would develop up through these stages we have mentioned? Is that your idea of the progress that should be made?

DR. DUNN: Well, we have not really tried to give these points in order of importance. We have not worked it out like that.

I have gone through the different stages through which a child would pass in the treatment o

the disease, and this ends up with the vocational training. Then, in addition to that, as an extra point, we need more staff all along the line to treat these children, and that is why I mentioned we need more facilities for training the people who treat these patients. We have had a considerable shortage here of physiotherapists in the past, and also of other experts such as psychologists.

To some extent, we are trying to remedy this, and the School of Rehabilitation has been established at the University partly with the assistance of the Child Care and Polio Foundation.

And this is now beginning, or has just begun to train physiotherapists. But no doubt similar institutions will be needed to train occupational therapists and other staff who are recommended in the management of these cases.

COMMISSIONER VAN WART: Thank you. That is all.

COMMISSIONER STRACHAN: How and where do you visualize dental treatment being rendered for the cerebral palsied?

DR. DUNN: I think dental treatment might be well given at the treatment centres, where the patients go for the other forms of management: Physiotherapy, schooling and social service.

COMMISSIONER STRACHAN: Is it not a recognized fact that in a great majority of these cases a general anaesthesia would be required?

DR. DUNN: Well, if that is the case. I do not know whether one can say that the great majority

the disease, and this ends up with the vocational training. Then, in addition to that, as an extra point, we need more staff all along the line to treat these children, and that is why I mentioned we need more facilities for training the people who treat these patients. We have had a considerable shortage here of physiotherapists in the past, and also of other support such as psychologists.

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COMMISSIONER STRACHAN: Is it not a recognized fact that in a great majority of these cases a general anaesthesia would be required?

DR. DUNN: Well, if that is the case, I do not know whether one can say that the great majority

does, because a lot of the older patients are able to cooperate fairly well. But, when a general anaesthetic is required, I would suggest that should be done in hospitals.

COMMISSIONER STRACHAN: And that would make it more urgent for a dental clinic in the hospitals?

DR. DUNN: Yes.

COMMISSIONER GIRARD: Dr. Dunn, on page 5 you say that the incidence of cerebral palsy has been calculated on about 150 per 100,000 population.

Then, you go on to say about one-third or 50 per 100,000 population require active treatment in special vocation and services.

You say further on that about 815 cases should now be getting active ambulatory treatment, who should have it, but only 515 patients are actually receiving it.

Is the difference in the number of patients now receiving treatment, which is about 760, due to the fact that you do not have the facilities, or is it due to the fact that you need better case-finding methods?

DR. DUNN: I would say primarily better case-finding methods, but the two are linked, because if you have, for instance, regional treatment centres scattered through strategic parts of the Province, I think these cases would come out more and come for treatment more. This has been the experience in other countries and in reports. Whenever a well-known treatment centre is established, the incidence of cerebral palsy in the whole area seems to be increasing and the cases come to the

does, because a lot of the older patients are able to cooperate fairly well. But, when a general anaesthetic is required, I would suggest that should be done in hospital.

COMMISSIONER DRACHAN: And that would make it more urgent for a dental clinic in the hospitals?

DR. DUMM: Yes.

Page 5 you say that the incidence of cerebral palsy has been calculated on about 150 per 100,000 population.

Then, you go on to say about one-third or 50 per 100,000 population require active treatment in special vocation and services.

You say further on that about 6% cases should now be getting active ambulatory treatment, who should have it, but only 5% patients are actually receiving it.

Is the difference in the number of patients now receiving treatment, which is about 750, due to the fact that you do not have the facilities, or is it due to the fact that you need better case-finding methods?

DR. DUMM: I would say primarily better case-finding methods, but the two are linked, because if you have the immense, regional treatment centres scattered through strategic parts of the Province, I think these cases would come out more and come for treatment more. This has been the experience in other countries and in reports. Whenever a well-known treatment centre is [illegible] more seems to be interesting and the cases come to the

surface.

COMMISSIONER GIRARD: You mean those 260 cases are not known to you?

DR. DUNN: Right.

COMMISSIONER GIRARD: And if they were known to you, you would have the facilities to treat them?

DR. DUNN: Well, if they became known to us, we would have to increase our facilities in the district.

MR. ROULSTONE: That would be a financial matter, too.

COMMISSIONER BALTZAN: Just one question.

You point out on page 4, and most interestingly, the many related conditions: Seizures, mental retardation, slow learners, etcetera.

My question is do you have several departments within your own institutions regarding management of these particular conditions, or do you then transfer them to one of the other organizations?

DR. DUNN: This varies somewhat with the disability. For instance, if the children with cerebral palsy have seizures, they may already have had some treatment for their seizures by a family physician and may have it under control. If the seizures are only mild, they may, with the cerebral palsy treatment centre, together with the family physician, work out the treatment satisfactorily themselves. If they feel it is an extra problem, needing expert care, they have on their panel of experts a neurologist. In the past, often there has been

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You point out on page 4, and most interestingly, the many resource conditions: nutrures, mental retardation, [illegible], etcetera.

My question is do you have several departments within your institutions regarding management of these psychiatric conditions, or do you turn over them to one of the outside organizations?

DR. DUNN: This varies somewhat with the community. For instance, if our counterpart general psychiatrist have sentence, they may already have had some treatment for their neurosis by a family physician and may have it under control. If the neuroses are only mild, they may, with the counterpart psychiatrist centre, together with the family physician, work out the treatment satisfactorily themselves. If they feel it is an extra problem, needing expert care, they have on their panel of experts a neurologist. In the past, often there has been

a neurologist sitting in on the screening panel at the Cerebral Palsy Clinic who can advise on this right away. If it is considered by the physicians at the Cerebral Palsy Clinic that they would like to have the advice of a neurologist, they can also refer the child to physicians, either privately or, if in the lower income group, they can refer them to the neurological out-patient clinic at the Vancouver General.

COMMISSIONER BALTZAN: Would one person like that who was so unfortunate as to have a number of these things belong to several organizations?

DR. DUNN: Does he have to belong?

COMMISSIONER BALTZAN: No, no. Could he be, say with the people who were organized to render help for the speech defects, and another one for the hearing defects. Could the same individual be listed statistically as belonging to more than one organization, not only the Cerebral Palsy, but, say, the Retarded Children?

DR. DUNN: On a private basis, there is nothing to stop a patient from being a member of the Cerebral Palsy Organization and also the B.C. Palsy Society, but from the point of view of registry of handicapped persons, they have cross-indexes, so the person who could only entered once as a disabled person.

THE CHAIRMAN: Mr.Brown, or Mr. Campbell, do you wish to add anything to what has been said?

MR. BROWN: No, Mr. Chairman.

MR. CAMPBELL: No, sir.

THE CHAIRMAN: Thank you very much, gentlemen.

---A short recess.

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THE CHAIRMAN: Mr. Brown, or Mr. Campbell, do you wish to add anything to what has been said?

MR. CAMPBELL: No, sir.

gentlemen.

---A short recess.

THE CHAIRMAN: The next brief is that of the British Columbia Speech and Hearing Association.

THE SECRETARY: This will be Exhibit 182.

---EXHIBIT NO. 182: Brief of British Columbia Speech and Hearing Association.

S U B M I S S I O N O F

BRITISH COLUMBIA SPEECH AND HEARING ASSOCIATION

APPEARANCES:

DR. DAVID KENDALL

MR. A. B. CLEMONS

THE CHAIRMAN: Yes, Mr. Clemons?

MR. CLEMONS: As the hour is growing late, Mr. Chairman, I propose to merely call your attention to certain points in this brief.

THE CHAIRMAN: Deal with the matter as you think best in the situation.

MR. CLEMONS: Mr. Chairman and members of the Commission, our Association is a very small association but we have the interests of a large number of people, children and adults at heart.

Speech and hearing therapy is essentially a para-medical service, and as such, forms an integral part of personal health services.

Since our modern world is making unprecedented demands on individuals for accurate and efficient communication; since all forms of impaired communication play a significant role in the individual's social and

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Speech and hearing therapy is essentially a para-medical service, and as such, forms an integral part of personal health services.

Since our modern world is making unprecedented demands on individuals for accurate and efficient communication; since all forms of impaired communication play a significant role in the individual's social and

economic adjustment; and since indications are that individuals with impaired speech and hearing make up one of our very largest handicapped groups; we submit that a comprehensive and coordinated extension of services and of research in communication problems is urgently needed.

Speech and Hearing Therapists are concerned with speech and hearing disorders in both adults and children: in adults; with problems of aphasia, of dysarthria, of stuttering, of voice, of voice and speech associated with laryngectomy, and of hearing; and in children; with problems of articulation, of stuttering and problems of rate and fluency, of voice, of voice and speech associated with cleft palate and other peripheral structural deviations, of voice and speech associated with cerebral palsy, of speech and language associated with mental retardation and delayed speech and language development, and of hearing.

Case loads will include all types of speech and hearing disorders. Since no surveys have been made in British Columbia, no statistics are available as to the numbers of speech and hearing handicapped requiring treatment, but we would estimate that 1% of the adult population require treatment. We submit that existing facilities, quantitatively and geographically are totally inadequate to service these numbers.

It is recommended that:

1. Facilities for speech and hearing diagnosis, assessment and therapy be provided at the Vancouver General and other hospitals.

2. Present and new speech and hearing facilities be

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It is recommended that:

1. Facilities for speech and hearing diagnosis, assessment and therapy be provided at the Vancouver General and other hospitals.

2. Present and new speech and hearing facilities be

extended to provide more adequately, not only for diagnosis, but also for treatment and follow-up of speech and hearing disorders of persons from outside Vancouver and Victoria.

3. The Provincial Government assume responsibility for fact finding studies and the tabulation of such information with regard to the speech and hearing handicapped as one of the groups of handicapped in the Province.

4. Present and new speech and hearing facilities be so organized as to facilitate substantial interdisciplinary co-operation with Neurology, Physical Medicine, Psychiatry, Social Work and Rehabilitation, for evaluation, treatment and research of the psychosocial factors such as vocational displacement, educational impairment and social handicap incurred by various speech and hearing handicaps.

5. Facilities, including the establishment of a clinical program, be provided at the University of British Columbia for the training of Speech and Hearing Therapists, at least to a standard comparable with both Great Britain and The United States.

Case leads will include all types of speech disorders. As in the case of adults, complete statistics are not available as to the numbers of speech handicapped children requiring treatment. But to give some indication of incidence, at least, among school age children, we submit the following: A Speech Survey, taken in June, 1959, in North Surrey showed that of 132 children referred, 39 showed defects requiring referral for further assessment and parent counselling. The City of Winnipeg,

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in 1952 stated that the number of children requiring speech correction was between 5%-10% of the school population. We would estimate the incidence of speech handicapped school children to be between 5%-10% of the school population in British Columbia.

Existing facilities are inadequate to service the numbers of speech handicapped pre-school children and school children.

It is recommended that:

1. Facilities be provided for comprehensive evaluation centres for diagnosis, assessment and therapy for children of all ages throughout the Province.
2. School Boards be encouraged to provide greater speech therapy services in conjunction with (1) above.
3. Facilities be provided for a cleft-palate program which would link together existing services for the better management of the cleft-palate child.
4. Similar facilities be provided for other problems requiring an integrated approach, such as stuttering and severe language problems.

Before I mention 5, if I might discuss for a moment, we like to think of Canada as an advanced country. With regard to the training of speech and hearing therapists Canada, it is one of the most backward countries in the world. I spent eleven years in South Africa and this work in South Africa with all its faults is far superior to Canada in this field. In England they have numerous training centres; in the United States they are scattered all over. In Canada, I cannot be absolutely sure

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of this, but I believe it is correct to the best of my knowledge there is a course at the University of Montreal which is in French and there is a brief course, I believe, underway at the University of Toronto.

5. Facilities for speech be extended to existing training programs for the mentally retarded.

6. Pertinent recommendations from the adult section be applicable in this section.

Again statistics are not available as to incidence, but we would estimate that between 3%-5% of school age children have hearing losses of a degree to require special treatment. And again, facilities are inadequate to provide for the needs of the Deaf and Hard of Hearing children in British Columbia.

It is recommended that:

1. The Provincial Government assume some responsibility for the financial support of existing and proposed diagnostic facilities for the Deaf and Hard of Hearing.

2. The Provincial Government assume responsibility for the provision of hearing aids for needy children.

3. Ways of insuring earlier ascertainment of hearing impairment in infants and young children be explored. Valuable time is lost through failure of physicians to recognize and refer children with hearing losses for treatment.

4. An Agency be established to provide for the rehabilitation and vocational placement of Deaf children.

It is desirable for any extension of a service program to be complemented by a research and evaluation program.

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4. An agency be established to provide for the rehabilitation and vocational placement of Deaf children. It is desirable for any extension of a service program to be con[illegible]

It is desirable that priority be given to the inclusion of payment for speech and hearing therapy under prepaid health schemes.

In conclusion, it is the submission of this brief that the problem of speech and hearing disabilities is a serious one, affecting the welfare of a great number of citizens and future citizens of Canada. This problem is not being adequately met and serious effort should now be directed toward meeting the problem.

I might add that the main purpose of this brief was to call to your attention the problem which might not otherwise have been called to your attention.

THE CHAIRMAN: Thank you very much, Mr. Clemons. In connection with the first paragraph on page 5 you refer to the survey in North Surrey and then in the City of Winnipeg. Last Summer there was an extensive survey in a very large area of Saskatchewan, the Humboldt-Wadiena Health Group which was financed by the Junior Red Cross as a private project and it is to be repeated again this year for reassessment. In addition to the survey to determine the numbers of those affected there was a certain amount of counselling given and the program is to be repeated this year to reassess the situation in the light of this one year's work because seriously affected persons, arrangements were made to have them brought to University Hospital where some physical defect might have been taken care of.

MR. CLEMONS: Thank you for that information.

THE CHAIRMAN: We will have to get the

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results to add them to the results of those two surveys.

MR. CLEMONS: I am originally from Saskatchewan and I think somewhere between South Africa and Vancouver I have lost touch.

THE CHAIRMAN: When we talk about speech therapists, we had to go to the United States to get the personnel to do this survey. Do you think you have any hope you may be able to get the recommendation you now make, that is to have therapists trained at the University of British Columbia, have you made any approach, has the road been cleared at all?

MR. CLEMONS: May I refer that question to Dr. Kendall. I was brought here from South Africa in 1953 with that purpose in mind, but there has been a slight delay.

DR. KENDALL: Yes, sir, I think we have the beginnings of this road cleared away now, offering through our college and faculty of education some preliminary training in speech therapy to teachers. It is my own view that this is only part of the right training. I think as we emphasized ...

THE CHAIRMAN: You are starting off with sufficient training so that might identify ...

DR. KENDALL: Yes. That is correct, but I think that ultimately one would see desirable training in, perhaps, a school of rehabilitation in which there would be much more emphasis on clinical work than it would be possible to provide within the Faculty of Education. I myself have appointments both in Faculty of Medicine and Education and hence can somewhat bridge this gap. In the

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training of therapists it is important that these aspects are presented.

THE CHAIRMAN: There is a reference on page 4 where you say there should be facilities provided for the selection and evaluation of hearing aids. That prompts me to ask the question that may be embarrassing. It is not intended that way. Do you find a reluctance on the part of those who are hard of hearing to make use of the hearing aids that are now available?

MR. CLEMONS: I would like to refer that to Dr. Kendall. It is his part.

DR. KENDALL: Yes, sir, I think that is undoubtedly true. I think that is one of the areas in which those organizations who are concerned with welfare of the hard of hearing are particularly concerned. There are many adults, particularly elderly people who acquire hearing loss and who may not be in a position to spend a great deal of money upon a hearing aid and who are very badly in need of advice as to what sort of aid to get and how to use it and so on. We don't presently have in this Province any centres to which such a person can turn. The audiologist who may or may not be involved, but may be consulted will give them advice, but he is then unable to follow this up in terms of giving training in the use of the hearing aid and the correlative use of lip-reading as well. We have a very small group of adults in Vancouver who are given some help from a teacher of the deaf in lip-reading, and that is all. We have been pressing for some time now for the development of an adult hearing centre in this City to meet the needs of the patients from all over

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the province. This is not one for which financial support of a sufficient degree has yet been made available to run the centre properly.

THE CHAIRMAN: Even amongst those to whom money would not be an obstacle in obtaining the best of hearing aids, why does a person wear glasses without any reluctance and yet will not wear a hearing aid?

DR. KENDALL: I suppose because hearing aids are so relatively new and glasses have been hallowed by a great many years of people wearing them. I think in the time that I have been in audiology, which is since just after the end of the last war, there has been a tremendous increase in the number of people who wear hearing aids. The wearing of hearing aids is now a much more common thing, both among adults and children. We still detect this vanity, or whatever it is, in people which prevents them sometimes from making use of something which would make a great deal of difference to their happiness and to their pursuit of life, a useful life.

MR. CLEMONS: May I add a personal reflection, sir, of the toughest person I ever had to persuade to wear a hearing aid. He had such a logical mind that he wasn't getting very far with lip-reading. He refused to guess. He had to know and that is practically impossible. I finally persuaded him to get a hearing aid, but he was -- I forget his exact title, but he was the Chief Justice of the Supreme Court of the Orange Free State.

THE CHAIRMAN: I know it's a feeling said to be common amongst judges. Dr. Baltzan?

COMMISSIONER BALTZAN: No questions.

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THE CHAIRMAN: Even amongst those to whom money would not be an obstacle in obtaining the best of hearing aids, why does a person wear glasses without any reluctance and yet will not wear a hearing aid?

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THE CHAIRMAN: I know this is a feeling said to be common amongst judges. Dr. Le Roux?

COMMISSIONER MARTIN: No questions.

THE CHAIRMAN: Miss Girard?

COMMISSIONER GIRARD: I have just one question, on page 6 there is the recommendation that the Provincial Government assume the responsibility for providing of hearing aids for needy children. Do you have any facilities now for giving hearing aids for needy children?

DR. KENDALL: Yes, I may answer that one. At the present time through the speech and hearing program which has its diagnostic clinic at Health Centre for children we have been able to get voluntary help from one particular voluntary organization, the Poliomyelitis Rehabilitation Foundation for Children who use hearing aids or adults who are unable to afford them. This has represented a considerable burden upon this particular voluntary organization. We have rather more than 150 children who have been through this particular program, children of pre-school age, and well over two-thirds of that number have been provided with hearing aids. I haven't the exact figures with me, but a considerable proportion of those parents have obtained help in the provision of the hearing aids. One must remember that with children the hearing aid has a short life. It gets dropped in the bath or is taken swimming. It is explored to see how strong it is with a hammer; cords and moulds and receivers are lost frequently and they are expensive to buy.

COMMISSIONER GIRARD: So far no needy child has gone without the proper equipment because you have this voluntary agency looking after that?

DR. KENDALL: That is correct.

THE CHAIRMAN: Miss Gibard?

COMMISSIONER GIBARD: I have just one question, on page 6 there is the recommendation that the Provincial Government assume the responsibility for providing of hearing aids for ready children. Do you have any facilities now for giving hearing aids for ready children?

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[illegible]

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COMMISSIONER GIRARD: Thank you.

THE CHAIRMAN: Thank you very much, gentlemen, Mr. Clemons and Dr. Kendall. This is a very helpful brief and one that contains factual information upon which our research people and we can go on. We will add to that the results of the survey I was telling you about.

DR. KENDALL: Thank you.

THE CHAIRMAN: I understand Mr. DuMoulin has a short submission.

THE CHAIRMAN: Thank you very much, gentlemen, Mr. Glemons and Dr. Kendall. This is a very helpful brief and one that contains factual information upon which our research people and we can go on. We will add to that the results of the survey I was telling you about.

DR. KENDALL: Thank you.

THE CHAIRMAN: I understand Mr. DuMoulin has a short submission.

SUBMISSION OF

THE CANADIAN HEART FUND

APPEARANCES:

MR. R. T. DuMOULIN

MR. DuMOULIN: Mr. Chairman and Commissioners, I appreciate very much your generosity in allowing me to say a word at this time. I think probably one reason you would gladly allow me to do so is to say I don't wish to waste the time of this Commission because I am representing the British Columbia Heart Foundation as one of its Vice-Presidents. Our President, Mr. Arthur Fouks whom your Chairman knows could not be here today. I ask permission to say a word. The B.C. Heart Foundation is collaborating with the Canadian Heart Foundation in preparing and submitting in Toronto, I believe, a brief to this Commission. However, I do want to take the opportunity of saying a word because this month the Canadian Heart Fund appeals for its funds to fight our drive against our number one health problem, heart disease and it is being carried on by the Heart Foundation across the country in this month of February. That is why I would like to not allow this Commission to leave Vancouver without hearing from us. Not let this Commission leave Vancouver thinking that the B.C. Heart Foundation were asleep and weren't aware of this very important problem. The thought that heart disease kills more Canadians each year than all other causes of death combined and is presently afflicting 1,400,000 people is alarming. However, perhaps the most serious factor is the increasing incidence in males between 25 and

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65 at the peak of their earning power and financial and family responsibilities. It is in this area that the Heart Foundation's research program is concentrated. We are sure you must be impressed, as we are, by the tremendous advances resulting from heart research in the last decade. There is every justification to expect similar progress in the next ten years, if the necessary funds for research are available.

I won't add any more because as I say, a full brief, which I might add, Mr. Chairman, I am trying to get them to make a little briefer, is in the course of preparation for submission to you in Toronto on behalf of the Foundation.

I just wanted to take a chance to say we are not asleep here and tell you that while we haven't submitted a brief to you directly it will be coming indirectly.

THE CHAIRMAN: Thank you, Mr. DuMoulin.

We will recess until nine o'clock tomorrow morning when we will proceed with the submission of the Canadian Mental Health Association.

---Whereupon the hearing adjourned.

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ROYAL COMMISSION ON HEALTH SERVICES

HEARINGS

HELD AT

VANCOUVER

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Proceedings of the Hearing
held in Vancouver, B.C.,
24th day of February, 1962

COMMISSION MEMBERS:

CHIEF JUSTICE EMMETT M. HALL - Chairman

MISS ALICE GIRARD, R.N.

DR. DAVID M. BALTZAN

PROF. O.J. FIRESTONE

MR. M. WALLACE McCUTCHEON, Q.C.

DR. C.L. STRACHAN

DR. ARTHUR F. VAN WART

COMMISSION COUNSEL:

MR. R.N. HALL, Q.C.

MEDICAL CONSULTANT:

DR. PIERRE JOBIN

DIRECTOR OF RESEARCH:

PROF. BERNARD BLISHEN

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PROF. RENNARD BLOYNA

MR. N. LAFRANCE

Vancouver, British Columbia
Saturday February 24, 1962

---ON RESUMING AT NINE O'CLOCK A.M.

THE CHAIRMAN: The first brief this morning is that of the British Columbia Association of Chiropodists.

THE SECRETARY: That will be Exhibit No. 183.

---EXHIBIT NO. 183: Submission of B.C. Association of Chiropodists.

SUBMISSION OF BRITISH COLUMBIA ASSOCIATION OF CHIROPODISTS

APPEARANCES:

DR. HILTON
DR. HEWITT
DR. MATHEWS
MR. SCHACHTER

MR. SCHACHTER: Mr. Chairman and Honourable Members of the Royal Commission on Health Services: We are the British Columbia Association of Chiropodists and as you probably no doubt are now aware, also podiatrists, both names being interchangeable. This morning we wish to present three statements from the executive of our Association. On my far right is Dr. Hilton, a chiropodist, Dr. Hewitt, a chiropodist and Dr. Mathews, a chiropodist and myself, Bernard Schachter, counsel for the Association.

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Just to briefly explain what we intend to say this morning, I will start off by mentioning a small point, namely, that the B.C. Association of Chiropodists is governed by a provincial statute since 1929 and they are policed by a Board of Examiners. The submissions that we intend to make this morning are with respect to recommendations and suggestions as contained in our brief. We do not want to repeat all the statistics that you have heard from other provincial associations and we do not intend to introduce a great deal of statistics of our submission for a college because there will be a Dominion brief when you return so we will not go into that.

Firstly, the B.C. Association of Chiropodists is most anxious to be included in any recommendations with respect to the national health programme that you may arrive at. We do not wish to suggest what you should arrive at, we just ask to be included.

I would like to put in a little recommendation of my own which Dr. Mathews will deal with subsequently, namely, that we have long felt that a reciprocity between B.C. and the other provinces would be desirable from our point of view and this would be facilitated by a uniformity of legislation throughout the Country. This is not the case today and Dr. Hilton will say something about that subsequently.

Finally, Dr. Hewitt would like to tell you about our clinic programme in British Columbia and Dr. Mathews will tell you about our hopes for a college and Dr. Hilton hopes at this time to submit four other

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recommendations as contained in our brief and to expand on them. I would like to introduce Dr. Hilton.

THE CHAIRMAN: Thank you, Mr. Schachter.

DR. HILTON: Mr. Chairman and Honourable Members of the Royal Commission on Health Services: As Mr. Schachter said and as you are probably aware, the brief will be submitted by the Canadian Podiatry Association in Ottawa which will provide the necessary amount of statistical material on the national level along with other statements of policy at this level. We, therefore, will refrain from saying anything which will be presented later, particularly with regard to agreement with the pro-health plan group or agreement with the co-belligerents. We will talk about our profession, with which we are familiar, attempting to help the Commission understand the scope of modern podiatry and its relationship to general medical practice. We will refer mainly to three unique situations which have occurred in the Province of British Columbia: one, a report by Mr. Justice A.M. Harper relating to the Chiropodity Act.

Two, a report by the Honourable Mr. Gordon MacG. Sloan, Chief Justice of British Columbia in his enquiry relative to the chiropodity profession and its relationship with the Workmen's Compensation Board.

Three, the opening and operation of the chiropodity clinic in the Vancouver General Hospital, this being the first time in Canada that a general hospital had installed such a clinic. At this point two main facts will require necessary support:

(a) That there is demand for the services

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(a) That there is demand for the services

of a podiotrist.

(i) The clinics will show demand.

(ii) The statement of prominent medical men will show demand.

(iii) The use of podiatry service by the D.V.A., by the Workmen's Compensation Board, by industrial organizations like General Electric, Proctor & Gamble who use podiatrists on their regular staff also shows demand.

(iv) Our very existence as professionals with a large number of patients being treated privately shows demand.

Now, the podiatrist is the logical professional to treat foot conditions because his education, his special equipment and his highly specialized training so qualifies him. I must, however, mention at this point that the podiatrist considers himself as part of the medical team. As a point of explanation on that, we are the first to recognize that all patients who come into our office with just a complaint of a pain in the foot do not necessarily have foot problems, these may be local manifestations to constitutional disorders which we are in a position to recognize that this is so and make the necessary recommendations.

In support of this I would refer you to the aforementioned report of Mr. Justice Harper dated the 1st of June, 1945 under the Public Enquiries Act relating to the Chiropodity Act which in part defines chiropodity as:

"A practice ancilliary -- handmaiden -- to medical practise in a limited field."

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A great number of the other facts in this report are at this point outdated but do make interesting reading as background information.

To further justify the progression of our profession I would like to read from a report made by the Honourable Gordon MacG. Sloan, Chief Justice of British Columbia, dealing with the Workmen's Compensation Act and handed down in 1952.

Mr. Justice Sloan, in this portion of this report, is answering one of the questions put to him:

"Is an injured workman to be allowed free choice of treatment by other than qualified medical doctors?"

He quotes Dr. J.H. McDermott, a physician and surgeon in Vancouver and subsequently President of the Vancouver Medical Association who wrote in the Vancouver Medical Association Bulletin the following:

"Till comparatively recently, this art was a very limited one, its limitations being due to a lack of adequate training on the part of its practitioners. The chiropodist of 50 years ago was not a highly trained man. The Encyclopedia Britannica defines him as 'One who treats the ailments of the hands and feet, or is consulted as to keeping them in good condition.': The use of the word is now restricted, however, to the care of the feet.....The word was first introduced in 1785 by a 'corn-cutter in Davies Street, London.' The medical practitioner tended to look down upon this individual as a 'corn doctor'. He regarded him with some suspicion and objected to his use of the title of doctor. He certainly

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This feeling of deregation still unfortunately exists to some degree in the minds of too many medical men. It is only when one sees the high degree of scientific attainment of the present day practice of chiropodity that one sees how completely unfair and unjustified it is. One sees how a highly trained man, ethical and professional in his outlook to whom specialists in orthopedica who surely would know what they were doing refer their patients constantly for consultation and treatment in the case of those patients who suffer from diseases of the foot. We see him doing work that we cannot do, and have not been trained to do -- we see that he has a knowledge of footwear, of supportive and therapeutic treatment, that we have never acquired and we find that our patients obtain relief and cures along the most highly scientific lines, lines which we ourselves have been trained to follow; a relief that we could never have given them.

One well known specialist in orthopedic surgery and now chief consultant for the Workmen's Compensation Board, Dr. J.R. Naden, went on record in 1945 before the Harper Commission as follows:

"I have sent some of my own family to chiropodists for care and I am amazed at the quality of their work and the more I have read of their literature the more important it appears to me that they have had this adequate training."

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THE CHAIRMAN: Mr. Schachter, you have submitted a brief and you asked to summarize it and deal with conclusions. If you have any further and ancilliary material such as reports we would be very pleased to have them but we cannot throw out the whole schedule of the Commission this morning to take up a complete study of the profession as I think you appear to be entering upon.

MR. SCHACHTER: Yes, we have extended ourselves.

THE CHAIRMAN: I am afraid we cannot inconvenience a number of other people.

MR. SCHACHTER: We will adapt ourselves and summarize.

THE CHAIRMAN: We are not unwilling to have this material, we want it, these reports but they should properly be filed as an appendix to your submission as you were instructed. If they are not available they can be sent to Mr. Lafrance so they will reach us and be part of the material as it is entered.

MR. SCHACHTER: We will do that, Mr. Chairman.

DR. HILTON: Mr. Chairman and Members of the Commission: The point we are trying to make is we are particularly lacking in clinical facilities to carry on the work we would like to carry on. As the brief in your possession says, we have two main ways of hoping to correct this situation; in other words if people were to get as toe conscious as they are tooth conscious we would be in the unhappy state of not having enough men to carry on. We suggested the establishment of the college and suggested

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DR. HEWITT: Mr. Chairman and Members of the Royal Commission on Health Services: my discussion regarding a chiropodity hospital clinic was to include the hospital, how it is established and how it operated. It operated for approximately ten years during which time the chiropodists in Vancouver gave to the indigent population of Vancouver some 30,000 treatments. At the end of this time we found that we were losing members to the United States, we were unable to get externes from the United States to help us in the clinic hospital which provided an extra in chiropodity to help us with our work in the clinic. We were no longer able to get these externes into Canada because of our laws and, consequently, we had to close the clinic some two years ago.

Subsequently, however, several members of our profession approached Dr. Whitelaw on the subject of going back into the hospital on a different basis. There are three of us now working in the clinic, one in orthopedics, one in the arthritic clinic and one in diabetes. When we approached Dr. Whitelaw on the subject of going back into the clinic he mentioned at that time there was no other clinic that could have been closed in the hospital other than the chiropodity clinic that

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caused so much turmoil; ours was truly missed. Regardless of the fact that the three chiropodists presently working in the clinic are on a one morning a week all year round basis, previously we were working for a month and somebody else would take our place and we would have a month off but now we are on a yearly basis. Regardless of that we still endeavour to establish certain research projects on the foot in the clinic; one having to do with the relationship of the postural problem to the feet. This was done in orthopedics or is being established in orthopedics and another one in arthritis, the relationship of arthritis to various foot classifications. We are, of course, concerned because we are now treating very few patients and the demand was so great when the clinic closed that we were getting behind in our schedule. We feel the only way to relieve this situation and in order to give the people of Vancouver the proper chiropodity care we must have an extern, somebody other than the existing chiropodist in the hospital to render continuing service to these individuals, people who are willing to carry on on this temporary basis until such time as an extern or intern can be provided. Three main factors involved in the problems in hospitals are: one is the present inability of a chiropodist in a clinic to refer a patient to outside practitioners for continuing care at a reasonable fee paid for by the Government and thus relieve the burden of clinical personnel. It has been mentioned there must be changes in chiropodity laws across Canada.

My third point is if hospital clinics are

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My third point is if hospital clinics are

to be supplied with interns and if we are going to have sufficient chiropodists to care for the foot health of the nation we must provide facilities for the education of these students here in Canada. This brings me to the conclusion of what I have to say and Dr. Mathews is going to discuss to some extent the problem of the Canadian Chiropodity College.

MR. MATHEWS: Mr. Chairman, I will only take a moment. We in the field of podiatry are concerned with the shortage of graduate podiatrists to serve the Canadian needs, both today and in the future. There are Canadians going into the field, but they are not practising in Canada. The main problem here is that there is no college or school of podiatry. Canadian graduates or Canadian practitioners, I should say, have reciprocity with 17 States in the United States, but we do not have reciprocity in British Columbia with one other province in Canada.

It is our recommendation that a school in Canada be established in one of the two provinces, either Ontario or British Columbia. Naturally, we would like to see the school in British Columbia. We therefore recommend that for the provision of high standards and the safety of economy that the proposed school be established under the guidance of a college of medicine.

This subject was brought up at the 1956 convention in Saskatoon at the University of Saskatchewan. At that time, the Dean of Medicine was Dr. J.W. MacLeod. He was approached for his opinion on this, and he told our group that he could see no problem in the establish-

to be supplied with interns and if we are going to have sufficient chiropodists to care for the foot health of the nation we must provide facilities for the education of these students here in Canada. This brings me to the conclusion of what I have to say and Dr. Mathews is going to discuss to some extent the problem of the Canadian

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ment of a school of podiatry under the guidance and assistance of the College of Medicine.

We would further recommend that in conjunction with this proposed School of Podiatry, a National Board of Examiners be set up similar to our Board of Examiners for British Columbia. This consists of three podiatrists and two doctors of medicine. Graduates from the proposed school would therefore be able to serve their internship or externship in a podiatry clinic or podiatry department in any major hospital in Canada, and proper foot care and treatment could be available to out-patients in all major hospitals in Canada. Upon completion of their internship, these graduates would be able to practise in any province in Canada.

MR. SCHACHTER: Those were the points we wished to cover.

THE CHAIRMAN: We understand your Association is going to be presenting a Canadian-wide brief, a national brief, at Ottawa or Toronto -- is it Ottawa?

MR. SCHACHTER: Yes, it is Ottawa.

THE CHAIRMAN: In which, I take it, this idea of establishment of a Canadian school will be developed at that time?

MR. SCHACHTER: Yes, at great length, sir.

THE CHAIRMAN: In the meantime, are you in a position to say whether your Association has made any overtures to any of the medical schools in Canada to include a School of Podiatry?

MR. SCHACHTER: Yes, sir.

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junction with this proposed School of Podiatry, a
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Mr. SCHACHTER: Yes, at great length, sir.

THE CHAIRMAN: In the meantime, are you in
a position to say whether your association has made any
overtures to any of the medical schools in Canada to
institute a school of Podiatry?

Mr. SCHACHTER: Yes, sir.

THE CHAIRMAN: A Department of Podiatry, whatever it might be?

DR. MATHEWS: We have not approached any University directly. We have only searched opinions at this time. And, as I mentioned, Dr. J.W. MacLeod, former Dean of Medicine, University of Saskatchewan, was very favourable in his opinion that a School of Podiotry should be opened under the guidance and assistance of a College of Medicine.

DR. HILTON: May I add, Mr. Chairman, that several years ago when Dr. Ranta, who is now the Medical Director of the Vancouver General Hospital, was addressing a seminar we had here, this question did come up, and he said, "Well, patience is probably the answer to the problem. We have been trying to get a medical faculty at the University of British Columbia for 50 years or so, and it now appears we will get it, and I rather think the next one will be a dental faculty. I do think you should continue and sooner or later you will probably get one too."

THE CHAIRMAN: Yes. Well, thank you very much, Mr. Schachter and gentlemen. We will be looking forward to hearing from your Association with its more complete brief at Ottawa.

The Pure Food Guild of British Columbia.

Mr. Moxey?

---EXHIBIT NO. 184: Submission of the Pure Food Guild of B.C., Inc.

THE CHAIRMAN: And your supplement will be known as Exhibit 184-A.

The QUESTION: A department of training, whatever it might be?

DR. HALLIS: We have not approached any University directly. We have only sounded opinions at this time. And, as I mentioned, Dr. J.W. Macleod, former Dean of Medicine, University of Saskatchewan, was very favourable in his opinion that a School of Dentistry should be opened under the guidance and assistance of a College of Medicine.

MR. HILTON: May I ask, Mr. Chairman, that several years ago when Dr. Kanta, who is now the Medical Director of the Vancouver General Hospital, was addressing a seminar we had here, this question did come up, and he said, "Well, perhaps is probably the answer to the problem. We have been trying to get a medical faculty at the University of British Columbia for 50 years or so, and is now apparent we will get it, and I rather think the next one will be a dental faculty. I do think you should continue and sooner or later you will probably get one too."

THE CHAIRMAN: Yes. Well, thank you very much, Mr. Schaefer and gentlemen. We will be looking forward to hearing from your association with its more complete brief at Ottawa.

The Pure Food Guild of British Columbia.

---EXHIBIT No. 140: Submission of the Pure Food Guild

THE CHAIRMAN: And your supplement will be known as Exhibit 140-A.

---EXHIBIT NO. 184-A: Supplement to Brief.

APPEARANCES:

DR. H.D. WARREN
MR. JOHN HARRISON
MR. JOHN CULLEN
MR. EDWARD MOXEY
MR. ARCHIE ALLEYNE
MRS. DORA BRUCE

MR. MOXEY: Your Lordship, a small treatise was inserted in the brief when we mailed it to you.

THE CHAIRMAN: Yes, we will identify it with the brief, considering it to be part of the brief.

MR. MOXEY: Yes, Your Lordship.

Your Lordship, Honourable Members of the Commission, I take great pleasure in reading my summary and conclusions.

THE CHAIRMAN: Please do, Mr. Moxey. Would you introduce those with you this morning?

MR. MOXEY: Thank you, sir.

I must ask you, with great deference, in view of the fact that in the First World War my left ear was completely destroyed by gunfire, I hear very, very well as a rule.

THE CHAIRMAN: We will try to speak up.

MR. MOXEY: Thank you, sir.

On my right, My Lord, is Dr. Harry B. Warren from the University of British Columbia. Next to Dr.

--Exhibit No. 184-A: Supplement to Brief.

Present:

DR. H.L. WEBER

MR. JOHN Hazelton

MR. JOHN CHALLEY

[illegible]

MR. MITCHELL ALLEYNE

MRS. LORA HUGHES

MR. CHALLEY: Your Lordship, a small treatise was inserted in the brief when we mailed it to you.

THE CHAIRMAN: Yes, we will identify it with the brief, considering it to be part of the brief.

MR. HAZELTON: Yes, Your Lordship.

Your Lordship, concerning the issues of the Commission, I take great pleasure in reading my summary and conclusions.

THE CHAIRMAN: Before to, Mr. Hoxey, would you introduce those with you this morning?

MR. HOXEY: Thank you, sir.

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THE CHAIRMAN: We will try to speak up.

MR. HOXEY: Thank you, sir.

On my right, My Lord, is Dr. Harry B. Warren from the University of British Columbia. Next to Dr.

Warren is Mr. John Harrison, the owner of a large organic farm at Richmond. Next to Mr. Harrison is Mr. John Cullen, formerly Regional Superintendent of the Pure Food & Drug in British Columbia for over 26 years. On my left is Mr. Archie Alleyne and Mrs. Bruce, the co-owners of Cameocroft Home for Retarded Children, My Lord.

Thank you very much.

SUMMARY AND CONCLUSION

The evidence in this brief provides indisputable proof that there is something radically wrong with our Pure Food and Drug laws. They seem to protect the manufacturer more than the consumer. Many drugs and chemicals after having been used and consumed by the public, and having been approved as SAFE by the Pure Food and Drug, have been found "after a period of years" to be harmful and even cancer forming. As an instance - "The food and drug administration of the U.S.A. banned the use of diethyl-stilbestrol". The chemical has been classified as a cancer-producing agent because it produced tumors on laboratory animals. (UPI report November 1961.)

Dr. W.C. Heuper, of the National Cancer Institute, declared that four food dyes - FD & GREEN NO. 1, 2, 3 and BLUE NO. 1 have been incriminated as potentially harmful, yet the Food and Drug Officials continue to allow these chamicals to be used in foods. (Note - Diethyl-stilbestrol has been used for many years both in this country and the U.S.A.)

Warren is Mr. John Harrison, the owner of a large organic farm at Richmond. Next to Mr. Harrison is Mr. John Cullen, formerly Regional Superintendent of the Pure Food & Drug in British Columbia for over 20 years. On my left is Mr. Ronnie Alloyne and Mrs. Bruce, the co-owners of Cameronsft Home for Retarded Children, Mr Lord.

Thank you very much.

Closing Comments

The evidence in this brief provides indisputable proof that there is something really wrong with our Pure Food and Drug laws. They seem to protect the manufacturers more than the consumer. Many drugs and cosmetics after having been used and consumed by the public, and having been approved as well by the Pure Food and Drug, have been found after a period of years to be harmful and even cancer forming. As an instance - "The food and drug administration of the U.S.A. banned the use of diethyl-stilbestrol". The chemical has been classified as a cancer-producing agent because it produced tumors on laboratory animals. (UPI report November 1971.)

Dr. W.C. Hueper, of the National Cancer Institute, declared that food dyes - FD & CRED NO. 1, 2, 3 and FLOR NO. 1 have been incriminated as potentially harmful, yet the Food and Drug Officials continue to allow these chemicals to be used in foods. (note - diethyl-stilbestrol has been used for many years both in this country and the U.S.A.)

I submit with great deference that the only solution for this appalling situation is for our Government to immediately adopt the following procedures:

1. To make the Drug administration and the Department of National Health and Welfare absolutely separate from each other. Note: This suggestion given to me by four retired superintendents of Pure Food and Drug Administration.
2. To appoint a permanent board of laymen and bio chemists to hold a "watching brief" on all activities of the drug administration insofar as suggested drug and chemical additives in our food, soil, and livestock are concerned.
3. There should be no interference by the medical profession as an organization, because they are studying symptoms (effects) rather than cause (as in the approval of the pollution of public water supplies with sodium fluorides which is an escapist attitude, and no guarantee of safety is assured to the individual consumer who is paying for pure water and not DRUGS).

In conclusion -- I submit as a manufacturer of natural foods; as a miller of whole wheat and other flours and grains without any chemicals; as a baker of various whole wheat breads, pies, cakes, cookies, etc. without any poisonous chemical additives whatsoever and supplying over fifty-five stores across Canada; with twenty-eight years in the NUTRITION field; as president of

I trust with great confidence that the only solution for this appalling situation is for our Government to immediately adopt the following procedures.

1. To make the Drug Administration and the Department of National Health and Welfare absolutely separate from each other. Note: This suggestion given to me by four retired superintendents of Pure Food [illegible]

2. To appoint a permanent board of lawyer and bio-chemists to hold a "running brief" on all activities of the Drug Administration Inspector as suggested drug and chemical additives in our food, soil and fertilizers are concerned.

3. There should be no interference by the medical profession or an organization, because they are study-ing symptoms (effects) rather than cause (as in the approval of the pollution of public water supplies with sodium fluoride) water is an essential commodity, and no guarantee of safety is assured to the individual consumer who is paying for pure water and not [illegible]).

In conclusion -- I submit as a manufacturer of natural foods; as a miller of whole wheat and other flours and grains without any chemicals; as a baker of various whole wheat breads, pies, cakes, cookies, etc. without any poisonous chemical additives whatsoever and supplying over fifty-five stores across Canada; with twenty-eight years in the NUTRITION field; as president of

the B.C. Eclectic Association of Chartered Herbalists; as "Health Columnist" for five local newspapers; as president of the Pure Food Guild of British Columbia Incorporated for Nutritional Research --

That this great nation is starving to death on a full stomach and DETERIORATING as a result of diverse NUTRITIONAL-DEFICIENCIES and POISONOUS CHEMICAL ADDITIVES IN OUR FOODS.

We must have better nutrition. We must not aim at the minimum requirements in these questions of nutrition but at the optimum requirements. If we do not achieve the optimum some other national will and they will be the masters, we the slaves, for we will surely fall an easy prey to the might and power of a stronger people. This brings to my mind the portentious utterance of the late Joseph Stalin, some years ago, when he said: "Russia has no intention of making war upon the peoples of the Western Democracies ... leave them alone and they will destroy themselves."

Let us therefore see that this evil prophesy does not come to pass (as it has done before in history).

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Let us therefore see that this evil prophecy does not come to pass (as it has come before in history).

I thank you, Your Lordship.

THE CHAIRMAN: Thank you, Mr. Moxey.

Mr. Moxey, in this first recommendation that you wish to make the drug administration and the Department of National Health & Welfare completely separate, why do you wish to do that?

MR. MOXEY: My Lord, I would put it this way: drugs have no part in health and I would compare it somewhat to the Lord telephoning the Devil and asking him to go into partnership with him.

I had the submission put to me by four retired superintendents for the Pure Food & Drug who were afraid, My Lord, to submit those reasons while they were in office, for an obvious reason.

THE CHAIRMAN: What advantages, administratively, would you see from separating the two administrations? If you are going to have a drug administration, anyway, what is the advantage of separating it from the other?

MR. MOXEY: Well, I think, My Lord, that then there will be a great improvement in the health of the people. I think that the Health Department will be able to use their own conclusions without advice as to add one part per million of benzoate of soda and sodium sulphur and other preservatives, which only preserve the store life of the food but does not enhance the health of the consumer.

THE CHAIRMAN: Does Mr. Cullen wish to add anything to that?

MR. MOXEY: Did you hear what His Lordship

I thank you, Your Lordship.

THE CHAIRMAN: Thank you, Mr. Moxey.

You will to make the drug administration and the department of National Health & Welfare completely separate, why do you wish to do that?

MR. MOXEY: My Lord, I would put it this way: drugs have no part in health and I would compare it somewhat to the Lord telephoning the Devil and asking him to go into partnership with him.

I had the impression put to me by four respected superintendents for the Food & Drug who were afraid, My Lord, to submit those reasons while they were in office, for an obvious reason.

THE CHAIRMAN: What disadvantages, administratively, would you see from separating the two administrations? If you are going to have a drug administration, anyway, what is the advantage of separating it from the other?

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THE CHAIRMAN: Does Mr. Gillen wish to add anything to that?

MR. MOXEY: Did you hear what [illegible]

said, Mr. Cullen?

MR. CULLEN: No, I did not.

MR. MOXEY: Mr. Cullen is another member of the Hard of Hearing Association, Your Lordship.

THE CHAIRMAN: Would you explain to Mr. Cullen what I said, if he is not hearing me?

MR. MOXEY: Yes.

Mr. Cullen, His Lordship wanted to know what benefit would be received if the drug administration was made separate from the Department of National Health & Welfare. What benefit would be derived if there was a separation, which I maintain in my brief.

MR. CULLEN: Well, I believe they could have their own Minister and act independent of the other division, which is the Division of Welfare, and in that way they could get more attention from the Government.

THE CHAIRMAN: Thank you, sir.

Mr. Moxey, we have your brief and you have referred to a number of articles and references in the brief. If there are any of these that you wish to file with us or send to us for further study, would you please have them sent to our Secretary in Ottawa?

MR. MOXEY: Thank you, My Lord.

THE CHAIRMAN: Now, is there anything else which you wish to add to what you have said this morning?

MR. MOXEY: My Lord, is there a possibility that any of the honoured speakers that I have brought with me this morning could be submitted questions. For instance, Mr. Harrison, from the Mylora Farms; we have

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MR. CULLEN: No, I did not.

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MR. MOXLEY: Thank you, My Lord.

THE CHAIRMAN: Now, is there anything else which you wish to add to what you have said this morning?

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analyzed -- we have three bio-chemists on the staff of the Pure Food Guild, and under analysis his vegetables, and carrots, for instance, have twice as much potasium and vitamin A as vegetables which have been forced up with poisonous chemicals.

In that manner, we are eating four times as much food and we are therefore trying to run the car with the choke out My Lord, if you will forgive me for using that expression. And whole foods -- we have 100 percent whole wheat flour, and it can be kept. The Allison Flour Mill Company sells flour to me which is guaranteed to be free of any chemicals or preservatives, and it will keep as long as eight and nine months. You can make whole wheat pies, cakes, and Yorkshire pudding without any addition of any deleterious substance, such as white flour, which I say is deleterious, which makes it like trying to run the car, as I say, with the choke out.

THE CHAIRMAN: Well, if anyone with you wishes to make a short statement, we will hear it.

DR. WARREN: Well, Your Lordship, if I might ask your indulgence for a few minutes.

First of all, I would like to thank Mr. Moxey and yourself and your committee for a chance to say a few words.

I am not a member of the Pure Food Guild, but I have been working in friendly association, as the University does, with anybody who is trying to find out the facts. During the past few years, we have unearthed some evidence which suggests that by a little extra

analyzed -- we have three bio-chemists on the staff of the Food Guild, and these analysis of vegetables, and carrots, for instance, have twice as much potassium and vitamin A as vegetables which have been forced up with poisonous chemicals.

In that manner, we are saving five times as much food and we are therefore trying to run the car with the chewing out in hand, if you will forgive me for using that expression. And whole foods -- we have 100 percent whole wheat flour, and it can be kept. The [illegible] guaranteed to be free of any chemicals or preservatives, and it will keep as long as eight and nine months. You can make whole wheat pies, cakes, and Yorkshire pudding without any addition of any deleterious substance, such as white flour, which I say is deleterious, which makes it like trying to run the car, as I say, with the choke [illegible].

The CHAIRMAN: Well, if anyone with you wishes to make a short statement, we will hear it.

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[illegible] I would like to thank [illegible] Honey in your [illegible] and you [illegible] for a change to say a few words.

I am not a member of the Pure Food Guild, but I have been working in friendly association, as the University does, with anybody who is trying to find out the facts. During the past few years, we have unearthed some evidence which suggests that by a little extra

co-operation between the medical authorities and the geologists, of all people, we can improve the health of our community.

Now, I did hope before today to have two supporting papers which have been accepted for publication and have been published.

We couldn't get the reprints in time to put them in your hands so that you wouldn't have to hear me at all.

THE CHAIRMAN: You could send them in later.

DR. WARREN: If I could have your indulgence I would like to impress on your mind what we are trying to do. Then I would suggest an illustration we had last year by Dr. Alan Price who is the health officer in West Devon. In West Devon there were many so-called old wives tales of some districts having a very very high rate in cancer so Alan Price decided that he would carry out an investigation and he took all the deaths in West Devon for 20 years and put them down on a map, 4 inches to the mile and placed every single death on this and discovered that he had an amazing pattern, the pattern being such that in some communities nearly 50 percent of the people died from cancer of all the deaths, and in other areas as little as 10 percent. He then set to work to try and find out what was the cause. I have in this paper outlined the results. I sent it back to him to see if I had quoted him correctly. He said our interest had given him great joy and his work had been taken up by others in British Columbia. The conclusion he came to, it was due to the water supply, and that this water, of

co-operation between the medical authorities and the geologists, of all people, we can improve the health of our community.

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THE CHAIRMAN: You could send them in later.

DR. HARVEY: If I could have your indulgence I would like to impress on your mind what we are trying to do. Then I would present an illustration we had last year by Dr. [illegible] who is our health officer in West Devon. In West Devon there were many so-called old wives tales or folk diseases having a very, very high rate in order so that he could not be would carry out an investigation and he took all the deaths in West Devon for 10 years and put them down on a map, 4 inches to the mile and placed every single death on this and discovered that he had an amazing pattern, the pattern being such that in some communities nearly 50 percent of the people died from cancer of all the deaths, and in other areas as little as 10 percent. He then set to work to try and find out what was the cause. I have in this paper outlined the results. I sent it back to him to see if I had quoted him correctly. He said our interest had given him great joy and his work had been taken up by others in British Columbia. The conclusion he came to, it was due to the water supply, and that this water, of

course, was correlated very closely with the geo-physical formations in this district and it must be a trace element problem. What I would like to get across is the difficulty, not ill-will, but the difficulty in getting co-operation. Talking to a neighbour in Cornwall he had the same idea, had got maps showing the different prevalence in Cornwall of cancer. He found this divided into peculiar patterns which couldn't be related to geography. When he came to try and get analyses as a practising doctor, he sent the analyses in to the Department of Agriculture and the Department of Agriculture after two years hadn't been able to get around to doing it because as they said if something in the soil was harmful what could they do. He then went to the Medical Council and asked them for analyses. He hopes in a year's time he may get results. I wanted to point out to you the co-operation of these two men who live 20 miles apart doing a co-operative programme. I feel in Canada and in British Columbia we have a Department of Agriculture making trace element surveys. We have the Department of Forestry with another set of people taking soil samples. We have geological surveys, all doing excellent work, and then we have the Government deronologist trying to assess all factors. The 49th Parallel has no boundaries as far as disease is concerned and I think if the members of your Committee realized that to fit the disease pattern in to planning areas such as school or electoral districts is wasting a lot of the public's money. My belief is that trace element studies be integrated so instead of doing this four times the

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trace element phase should be by co-operation, and by spending much less we could get much more information. I have papers, they are not yet published. I will try and get them to you afterwards. In the meantime I wondered if I might present to you copies of a speech in which I introduced this subject last year which has also to be published, but may not be published while this Commission is sitting.

THE CHAIRMAN: That is fine. We will be pleased to get your papers. What department of the University are you with?

DR. WARREN: I am in the Department of Geology. Might I explain to you how on earth I came to be.

THE CHAIRMAN: It is all right.

DR. WARREN: I was simply trying to find ore deposits some 15 years ago without having to do any digging. I am a poor digger. Every time I take a shovel in my hands my friends tell me I haven't had much practise. I was snipping leaves from trees to test the kinds of soil. This is now a thing that is a common practice with some of the major companies. We found some of the elements very harmful to people.

THE CHAIRMAN: That is the subject of your speech, I take it.

DR. WARREN: That was finished. I wanted you to know that I wasn't getting into health because I didn't have anything better to do. When we found poisonous substances in trees we found them in vegetables and that is the evidence you have before you in the paper.

MR. MOXEY: Could I prevail on your time just

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DR. WARREN: I am in the Department of Geology. Might I explain to you how on earth I came to be.

THE CHAIRMAN: It is all right.

DR. WARREN: I was simply trying to find one deposit some 15 years ago without having to do any digging. I am a poor digger. Ever since I take a shovel in my hands my friends tell me I haven't had much practice. I was spiring leaves from trees to test the kinds of

with some of the major companies. We found some of the elements very harmful to people.

THE CHAIRMAN: That is the subject of your speech. I take it.

DR. WARREN: That was finished. I wanted you to know that I haven't getting into health because I didn't have anything better to do. When we found poisonous substances in trees we found them in vegetables and that is the evidence you have before you in the paper

MR. MCKAY: Could I prevail on your time just

to have a word with Mr. Alleyne to explain the operation of the Cameo Croft Home. Mr. Alleyne.

MR. ALLEYNE: Thank you very much, Your Lordship, Members of the Commission:

In presenting evidence that Cameo Croft, under Provincial Institutions License No. 1728, is qualified to carry out its System of Physical Re-education, it must be pointed out that several of the eminent people quoted -- Medical Doctors, Members of Governments and other reliable persons visited Cameo Croft School and observed this program in operation, and are, therefore, qualified to make said statements.

For additional Documentary evidence, we also refer you to the confidential Reports issued to the B.C. Dept. of Health and Welfare by The Fraser Valley Health Unit, The Physiotherapist Association of B.C. and the Provincial Director of Rehabilitation. Said reports could be available for study by this Commission on request.

SUBJECT: "The Importance of Proper Diet and Physical Training."

Cameo Croft is the only Institution and Residential School in British Columbia using a basic nutritional program as advocated by the Pure Food Guild of B.C. A program featuring whole grains, organically grown fruits and vegetables, whole nuts, unpasteurized honey and other unprocessed foods.

We submit that as a result of the careful selection and preparation of foods, chosen for their high nutritional contents and for easy digestion, and

[illegible]

of the Cases on it form. Mr. Gilmore.

Mr. AUDITOR: Thank you very much, Your [illegible]

In presenting evidence that Cases Co. [illegible] under Provincial Registration Number No. 1/28, is qualified to carry out its System of Physical Education, it must be pointed out that several of the client people quote -- Indian Agencies, Bands of Government and other Public & Separate Limited Cases Court Schools are observed this program in operation, and are, therefore, our first to make such statements.

For so-called documentary evidence, we also refer you to the confidential reports issued to the B.C. Dept. of Health and Welfare by the Fraser Valley Health Unit, the Medical Department of U.C. and the Provincial Bureau of Vital Statistics. Such reports will be available for study by this Commission on request.

Dr. [illegible]: The Department of Physical Education and Physical [illegible]

Cases Court is the only Institution and Residential School in Western Canada using a Dr. [illegible] nutritious program as advocated by the Dept. Food Guide of B.C. A program featuring whole grains, organically grown fruits and vegetables, whole nuts, unprocessed honey and other unprocessed foods.

The culture went as a result of the careful selection and preparation of foods, chosen for their high nutritional contents and for easy digestion, and

assimilation the following results were obtained:

Here is one of them that proves my point.

THE CHAIRMAN: He is a nice looking boy but we cannot make him an exhibit.

Within six months, the first obvious improvement in their health was freedom from constipation, manifested by clearer eyes, better complexion and skin tone. Weight reduction in the overweight and a gain in weight of the underweight followed. Freedom from colds, improved mental alertness, sound sleep, and positive changes in temperament were noted in all the students.

Therapeutic or Remedial Exercises in combination with massage were responsible for relieving rigid joints and tense muscles, improved muscle tone, the releasing of spastic conditions and the elimination of Athetosis (constant involuntary movements). Mouth breathing and drooling were corrected, cross eyes straightened to a remarkable degree and deformed heads took on a more natural contour.

It is a known fact that as retarded children grow up some of their handicaps tend to crystallize if nothing is done to help it, and in addition to their inherent handicaps they often acquire additional idiosyncracies, through injury and/or environmental factors that could be eliminated by understanding and proper training.

The Program of daily physical exercises designed especially for this group and given in one hour sessions soon showed remarkable improvement in locomotion, posture, walking, standing and sitting. The outstanding results of these daily exercises, which

rehabilitation the following results were obtained:

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The Program of daily physical exercises designed especially for this group and given in one hour sessions soon showed remarkable improvement in locomotion, posture, walking, standing and sitting. The outstanding results of these daily exercises, which

includes body mechanics, were "Neuromuscular precision and endurance."

THE CHAIRMAN: Mr. Alleyne, I thought you were going to discuss the Cameo Croft Institution rather than give us a dissortation on the matter of retarded children. We have heard that from many sources. If you have a paper you wish to leave with us we would be happy to take it.

MR. ALLEYNE: I have already submitted that paper.

THE CHAIRMAN: I thought you wanted to talk about this project.

MR. ALLEYNE: Mrs. Bruce can do that

THE CHAIRMAN: Just as you like.

MR. ALLEYNE: Thank you.

THE CHAIRMAN: We have the paper you are going to read.

MRS. BRUCE: Just a few words: we are in a unique position in the approach we take in Canada, we have undertaken to approach this problem of retardation by physical rather than mental.

THE CHAIRMAN: This is a novel aspect and the one I wanted to hear from you about.

MRS. BRUCE: Everything we do is the physical approach. We support that with food and physical education, physical education for physical purposes. Everything is physical. By improving them physically we automatically improve them mentally.

THE CHAIRMAN: How many children have you got?

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MRS. BRUCE: Everything we do is the physical approach. We support that with food and physical [illegible]. Everything is physical. By improving them physically we automatically improve them mentally.

THE CHAIRMAN: How many children have you got?

MRS. BRUCE: We have seven.

THE CHAIRMAN: Where do they come from? How do they come to you?

MRS. BRUCE: Privately from parents, four in Vancouver and the other three in the country. There are no facilities in British Columbia outside of the Woodlands School for this purpose and we do this on a private basis because the need is so great. Woodlands School has a population of about 1500. They have at least 600 on the waiting list and the applications are accumulated at the rate of 100 a year. How can we explain this to people. I think if you realize the dire need of parents of retarded children and handicapped children -- we are interested in the bottom of the barrel group, which is the ones that are physically handicapped as well as the mentally retarded. They don't seem to fit in anywhere. They are generally left in closets and back rooms and what have you.

THE CHAIRMAN: Have you any provisions for expansion?

MRS. BRUCE: Yes, we have. We are in the country, ideally located on the mountainside, a beautiful site, ideal for boys to climb trees and fish and what have you. It is the kind of place any boy would like to go. It is a residential school. We have made it so.

THE CHAIRMAN: Do you receive any government assistance?

MRS. BRUCE: No, we don't. These parents are financially unable to carry out treatment in such a

THE CHAIRMAN: Where do they come from? How do they come to out

in Vancouver and the other towns in the country. There are no institutions in British Columbia outside of the private hospitals because the need is so great. Woodlands School has a population of about [illegible]. They have at least 600 on the waiting list and the applications are accumulating at the rate of 100 a year. How can we explain this to people. I think if you realize the dire need of a wide of retarded children and handicapped children -- we are interested in the action of the Department, which is the one that are physically handicapped as well as the mentally retarded. They don't seem to fit in anywhere. They are generally left in closets and back rooms and what have you.

THE CHAIRMAN: Have you any provisions for

MRS. [illegible]: No, no there. We are in the country, ideally located -- the mountainside, a beautiful site, ideal for boys to climb trees and fish and what have you. It is the kind of place any boy would like to go. It is a recreational school. We have made it so.

THE CHAIRMAN: Do you receive any government assistance?

MRS. [illegible]: No, we have not [illegible] in each a

place as ours. As you will realize we do everything we can during this period in which normally they would be going to school, from the ages of 6 to 16, and put them in this place with Mr. Alleyne, he is a physio-therapist of 18 years' experience. He is a physical therapist. He is teaching the retarded children, he is taking the crippled boys like this boy who can do extremely difficult exercises that require co-ordination and skill, endurance and concentration. All these things they are learning is a system of education for handicapped retarded children who could not be educated.

THE CHAIRMAN: It is a pilot project in that sense?

MRS. BRUCE: It is, yes.

THE CHAIRMAN: How do you propose to bring it to the attention of the authorities and those who might be induced to extend it in other areas?

MRS. BRUCE: We are using every way we can think of. This probably is one of them. The municipalities are backing us. In fact I have a letter from them for you. The municipalities have no money over for purposes like this. They urge the provincial government support us by doing something in the way of maintenance. You could have a health insurance policy. It is an act of God. Nobody is to blame for such a child. Anyone who is perhaps disabled by war is helped. It should be something like that.

THE CHAIRMAN: They should come under some form of health service.

MRS. BRUCE: Definitely. Ours is in the

place as ours. As you will realize we do everything we can during this period in which normally they would be going to school, from the ages of 6 to 16, and put them in this place with Dr. Allayne, he is a physio-therapist of 16 years' experience. He is a physical therapist. He is teaching the retarded children, he is teaching the cripples. Is this the type of extremely difficult exercises that require co-ordination and skill, endurance and concentration. All these things they are learning is a system of education for handicapped retarded children who could not be educated.

THE CHAIRMAN: It is a pilot project in that sense?

MR. ROBIN: It is, yes.

THE CHAIRMAN: How do you propose to bring it to the attention of the authorities and those who might be induced to extend it in other areas?

MR. ROBIN: We are doing every way we can think of. This somebody is one of them. The municipalities are backing us. In fact I have a letter from Iran for you. The municipalities have no money over for projects like this. They give a provincial government support only doing something in the way of maintenance. You could have a health insurance policy. It is an act of God. Money is no place for such a child. Anyone who is mentally disabled by war is helped. It should be something like that.

THE CHAIRMAN: They should come under some form of health service.

MR. ROBIN: Definitely. Ours is in the

area of mental health. We feel we give a health service in the area of mental health.

THE CHAIRMAN: Are these children in any way wards of the Province or the Department?

MRS. BRUCE: They are not, none that we have.

MR. ALLEYNE: They were.

MRS. BRUCE: They are on application. We have no facilities for these children. We cannot continue to provide a free service. These parents are not able to pay for the service they are getting. We are donating, as it were, our services in order to prove a point that something can be done for this group.

THE CHAIRMAN: You are going it according to Mr. Alleyne on a principle of ...

MRS. BRUCE: Physical education.

THE CHAIRMAN: It is most interesting and we are indebted to you for having brought it to our attention here this morning.

MRS. BRUCE: Thank you very much. I wish we had two minutes so you could see what Mr. Alleyne has done in muscular precision.

THE CHAIRMAN: I don't think so.

MR. ALLEYNE: Could I make a few remarks, Mr. and Mrs. Bruce donated their premises for the service. They have gone into debt to promote this project. I have worked for the past two years for nothing, so have the Bruces. At this point if we don't get some financial aid from some source the project will have to be dropped. We can't go on beyond the end of May which will complete two years at this time.

ment of mental health. We feel we give a health service in the area of mental health.

THE CHAIRMAN: Are there children in any wards of the Province or the Department?

have no facilities for these children. We cannot continue to provide free service. These parents are not able to pay for the service they are getting. We are dorthing, as it were, our services in order to prove a point that something can be done for this group.

MR. LA ADAIR: You are doing it according to Mr. Allerne or a principle of ...

THE CHAIRMAN: It is most interesting and we are indebted to you for having brought it to our attention here this morning.

Had two minutes so we could see what Mr. Allerne has done

THE CHAIRMAN: I don't think so.

MR. MACKAY: Could I make a few remarks.

Mr. and Mrs. Byrne operated their business for the service they have gone into debt to present this project. I have worked for the past two years for nothing, so have the bruces. At this point if we don't get some financial aid from some source the project will have to be dropped. We can't go on beyond the end of May which will coincide the year at this time.

THE CHAIRMAN: You have no institution or service club or anything of that kind?

MR. ALLEYNE: Not yet.

THE CHAIRMAN: To which you could appeal?

MR. ALLEYNE: The difficulty was, we started on a resort licence and worked on that. Eventually we got a provincial licence in August of last year. I am not a medical doctor, that was one of the obstacles which came up. We do have a medical doctor, we have several medical doctors now who do work for us. We all know the machinery of government moves slowly. We are finding it like that for us. In the past two years our average income per month was $37. That is all we netted as income. For food it cost $85, just for food, so you can see our position.

THE CHAIRMAN: Thank you very much. Thank you Mr. Moxey for your appearance here this morning with your associates. The material which you have filed and which has been filed will have our consideration and study.

MR. MOXEY: Thank you My Lord and Members of the Royal Commission. I am very pleased with the reception you have granted the speakers and myself. I thank you very much.

THE CHAIRMAN: The next submission will be the Burnaby Chamber of Commerce.

THE SECRETARY: Exhibit 185, sir.

---EXHIBIT NO. 185: Submission of the Burnaby Chamber of Commerce.

THE CHAIRMAN: You have no institution or service club or anything of that kind?

MR. MILLER: Not yet.

THE CHAIRMAN: To which you could appeal?

MR. MILLER: The difficulty was, we started on a permit license and worked on that. Eventually we got a provincial license in August of last year. I am not a medical doctor, that was one of the obstacles which came up. We do have a medical doctor, we have several medical doctors now who do work for us. We all know the machinery of government moves slowly. We are finding it like that for us. In the past two years our average income per month was $37. That is all we netted as income. For food it cost us, just for food, as you

THE CHAIRMAN: Thank you very much. Thank you Mr. Moser for your brief and have this morning with your associates. The material which you have filed and which has been filed will have our consideration and

MR. MOSER: Thank you Mr Lord and members of the Royal Commission. I am very pleased with the reaction you have granted the speakers and myself. I thank you very much.

THE CHAIRMAN: The next submission will be the Burnaby Chamber of Commerce.

---EXHIBIT No. 188. Submission of the Burnaby Chamber of Commerce.

APPEARANCES:

DR. J.R. SIDDALL
MR. ANGUS MacDONALD
MR. JACK COWLING

SUBMISSION OF BURNABY CHAMBER OF COMMERCE - - -

DR. SIDDALL: Mr. Chairman and Members of the Royal Commission, thank you for having us here and for accepting our brief which was a little late. I imagine you are getting quite tired of all this weather and are anxious to get back east to your 22 degrees below zero. I will read the conclusions and recommendations.

The following is a synopsis of the major conclusions and recommendations of the submission of the Burnaby Chamber of Commerce to the Royal Commission on Health Services:

CONCLUSIONS

A. Our present total Federal Health & Welfare expenditure is 45.7% of the total Federal Government Tax Revenue. These costs under a Federal Government Medical scheme would no doubt lead to a much greater increase as experienced by the United Kingdom's National Health Service beginning in 1948, at a cost of two hundred million pounds, spiralling to eight hundred and sixty-seven million pounds at present, of which the sum of six hundred and sixty-three million pounds is by increased tax.

DR. J.R. SIGMAN

MR. ARNOLD HARDMAN

A. MAY COMMITTEE

MR. SIGMAN: Mr. Chairman and Members of the Royal Commission, thank you for having us here and for accepting our brief which was a little late. I imagine you are getting quite tired of all this weather and are anxious to get back east to your 22 degrees below zero. I will read the conclusions and recommendations.

The following is a synopsis of the major conclusions and recommendations of the submission of the Kinsey Chamber of Commerce to the Royal Commission on Health Services:

A. The present total Federal Health & Welfare expenditure is 45.7% of the total Federal Government Tax revenue. These costs under a Federal Government Medical scheme could no doubt lead to a much greater increase as experienced by the United Kingdom's National Health Service beginning in 1948, at a cost of two hundred million pounds, approaching to eight hundred and sixty-seven million pounds at present, of which the sum of six hundred and sixty-three million pounds is by increased tax.

B. The phrase, "free medical care", is misleading to many citizens and that no political party should suggest a broad comprehensive medical coverage for Canadians without producing a quotation, rather than estimate, as to the actual cost of such proposal.

We say this because we have been hearing so many people aspiring to political positions say they would like to give us something free. We know there is no such thing, there is no Santa Claus.

C. This Chamber of Commerce is in agreement with the Canadian Chamber of Commerce that a system of so-called "socialized medicine" is undesirable.

We felt there were some recommendations to be made on prepaid insurance.

1. Prepaid medical insurance by non-seasonal workers, payable during first six months to one year of employment to cover medical expenses for any unexpected period of unemployment.

2. Prepayment of a medical plan by seasonal workers for anticipated periods of unemployment.

3. Continuity of prepaid insurance through the medium of prepayment or transitional-period payments.

4. Elimination of "poor-risks" clauses from present or future medical plans.

5. A Government-sponsored medical care programme for those incapable of paying a premium.

6. Elimination of abuses of the Federal Hospital Insurance and diagnostic Services Act (Bill 320).

7. Requirement of much better treatment facilities than presently available for drug addiction, a

B. The phrase, "free medical care", is misleading to many citizens and that no political party should suggest a broad comprehensive medical coverage for Canadians without producing a quotation, rather than estimate, as to the actual cost of such proposal.

We say this because we have been hearing so many people applying to political positions say they would like to give us something free. We know there is no such thing, there is no Santa Claus.

C. This Chamber of Commerce is in agreement with the Canadian Chamber of Commerce that a system of so-called "socialized medicine" is indefensible.

We felt there were some recommendations to be made on prepaid insurance.

1. Prepaid medical insurance by non-seasonal workers, payable during first six months to one year of unemployment to cover medical expenses for any unexpected period of unemployment.

2. Prepayment of a medical plan by seasonal workers for anticipated periods of unemployment.

3. Continuity of prepaid insurance through the medium of prepayment or transitional-period payments.

4. Elimination of "cream-skim" clauses from present or future medical plans.

5. A Government-sponsored medical care programme for those incapable of paying a premium.

6. Elimination of abuses of the Federal Hospital Insurance and diagnostic Services Act (Bill 320).

7. Requirement of much better treatment facilities than presently available for drug addiction, a

serious problem in mental health.

THE CHAIRMAN: Thank you. Do Mr. MacDonald or Mr. Cowling wish to add anything at the moment?

MR. COWLING: Not at the moment.

THE CHAIRMAN: Dr. Siddall, your Item 6, Elimination of Abuses of the Federal Hospital Insurance & Diagnostic Services Act, what do you mean by that and what have you in mind?

DR. SIDDALL: Could I go back and read the page of the brief which is quite explanatory.

THE CHAIRMAN: What page?

DR. SIDDALL: Page 2, Item 9.

THE CHAIRMAN: Very well.

DR. SIDDALL: 9.

(a) The Federal Hospital Insurance and Diagnostic Services Act - Bill 320, passed by the House of Commons on April 10, 1957, covers in-patient services at standard or public ward level, including necessary nursing service, laboratory, radiological and other diagnostic procedures, together with the necessary interpretation for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability.

Do you wish me to continue?

THE CHAIRMAN: I was concerned with the word "abuses".

DR. SIDDALL: I think I will come to this.

(b) In British Columbia the Diagnostic Services part of the Act has not been implemented on an out-patient basis to date. It is quite possible that

serious problem in mental health.

Do Mr. Morning wish to add anything at the moment?

MR. COMLING: Not at the moment.

THE CHAIRMAN: Mr. Gerald, your Item 6, Elimination of Abuses of the Federal Hospital Insurance & Diagnostic Services Act, what do you mean by that and what have you in mind?

DR. ST. JAMES: Could I go back and read the page of the brief which is quite explanatory.

THE CHAIRMAN: What page?

DR. ST. JAMES: Page 2, Item 6.

THE CHAIRMAN: Very well.

(a) The Federal Hospital Insurance and Diagnostic Services Act - Bill 320, passed by the House of Commons on April 14, 1957, covers in-patient services at standard or public ward level, including necessary nursing service, laboratory, radiological and other diagnostic procedures, together with the necessary in-terpretation for the purpose of maintaining health, preventing disease and assisting in the diagnosis and treatment of any injury, illness or disability.

Do you wish me to continue?

MR. STEWART: Yes, I think I will come to this word "abuses".

MR. ST. JAMES: I think I will come to this.

(b) In Western Canada the Diagnostic Services part of the Act has not been implemented on an out-patient basis to date. It is quite possible that

there is concern about over-utilization of such service despite the fact that it is conceded that certain current hospital in-patient admissions are for diagnostic service only. As far as the patient is concerned, the $1.00 co-insurance charge per day is a very small sum to pay in comparison to X-ray charges as an out-patient. The patient who pays $30.00 for X-rays could have himself admitted to hospital for $1.00 a day and have a rest.

THE CHAIRMAN: Are you in a position to say as to the extent to which this happens?

DR. SIDDALL: No, I am not. I do not think anyone keeps records of it.

THE CHAIRMAN: Have you any idea of whether it is isolated cases, or whether it is rather broadly done?

DR. SIDDALL: No, this is a complaint you will hear from hospital administrators, it is not just something of mine.

(c) In some areas of the Province a rather liberal translation of the phrase in the Act, "necessary nursing service", is considered to mean special or private duty nursing. If such is the correct interpretation, it would appear that the Act has exceeded what has been generally considered in this province as additional cost to the patient. If true, such an interpretation can raise costs considerably, again as result of over-utilization by misuse.

(d) The basic problem in this particular type of social legislation is that control of expenditures is too widespread. While the physician is

there is concern about over-utilization of such service despite the fact that it is conceded that certain current hospital in-patient admissions are for diagnostic service only. As far as the patient is concerned, the $1.00 co-insurance charge per day is a very small sum to pay in comparison to X-ray charges as an out-patient. The patient who pays $10.00 for X-rays could have himself admitted to hospital for $1.00 a day and have a rest.

THE CHAIRMAN: Are you in a position to say as to the extent to which this happens?

DR. STODALE: No, I am not. I do not think anyone keeps records of it.

THE CHAIRMAN: Have you any idea of whether it is isolated cases, or whether it is rather broadly done?

DR. STODALE: No, this is a complaint you will hear from hospital administrators, it is not just something of mine.

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(d) The basic problem in this particular type of social legislation is that control of expenditures is too widespread, while the physician is

actually the key person in the triangle, the patient considers that he is entitled, as a taxpayer, to any and all hospital services required or not.

THE CHAIRMAN: What do you mean by that, a person goes in for diagnosis?

DR. SIDDALL: He is entitled to it regardless of whether the doctor thinks he should go in or not.

THE CHAIRMAN: He wants his whole body X-rayed?

DR. SIDDALL: He could have it if he wants to.

THE CHAIRMAN: He thinks he has the right to say that and not the doctor?

DR. SIDDALL: He should not have. I might feel as a physician he should go in and have X-rays, I do not think he should go in if he is not that ill.

(e) (i) The most important is the complete co-operation of the doctors, for it is they alone who admit, discharge and prescribe.

(ii) The provision of chronic care facilities, either as separate units or in conjunction with the acute care hospital, is necessary. Recent figures (1960) for Canada show that the rate of chronic and convalescent beds to acute beds runs about one to four in Public General and Public Special hospitals. The provision of active-treatment chronic beds, or rehabilitation or activation beds is an important requirement to cost control as such care is approximately one-half the cost of acute hospital care. Nursing home facilities for the bedridden, aged and infirm, as well

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as Home Nursing Care programme, are also important segments in the complete programme.

Briefly, we have trouble at times getting chronically ill patients who have recovered away from hospital, they still need some care and there are not these facilities for these people outside. This is a big problem.

COMMISSIONER FIRESTONE: This question is directed to you or any of your associates if they wish to answer. If I may just follow up the question the chairman just raised about abuses of the Federal Hospital Insurance and Diagnostic Services Act, in your Paragraph 9b you say:

"In British Columbia the diagnostic service part of the Act has not been implemented on an out-patient basis to date."

Would the Burnaby Chamber of Commerce recommend that such services be covered under this programme?

DR. SIDDALL: No, unless we have straight in our minds what you mean by out-patient services and what I mean.

THE CHAIRMAN: We are wondering if you prefer them to go into the hospital for $1.00 a day to get $30.00 worth of work?

DR. SIDDALL: No.

COMMISSIONER FIRESTONE: Would you be good enough to give us your definition of what you mean?

DR. SIDDALL: Really the problem -- take the Emergency Department of a hospital, it is referred to as out-patient care. I might come up to the hospital as a

as home nursing care programme, are also important segments in the complete programme.

Briefly, we have trouble at times getting chronically ill patients who have recovered away from hospital, they still need some care and there are not these facilities for those people outside. This is a big problem.

COMMISSIONER FINKELSTEIN: This question is directed to you or any of your associates if they wish to answer. If I may just follow up the question the chairman just raised about abuses of the Federal Hospital Insurance and Diagnostic Services Act, in your Paragraph 3b you say:

"... part of the Act has not been implemented on an out-patient basis to date."

Would the Burnaby Chamber of Commerce recommend that such services be covered under this programme?

DR. SLOAN: No, unless we have straight in our minds what you mean by out-patient services and what I mean.

THE CHAIRMAN: We are wondering if you prefer that to go into the hospital for $1.00 a day to get $30.00 worth of work?

DR. :

COMMISSIONER FINKELSTEIN: Would you be good enough to give us your definition of what you meant

DR. SLOAN: Really the problem -- take the emergency department of a hospital, it is referred to as out-patient care. I might come up to the hospital as a

prospective patient and might have been skiing and I think I hurt my leg pretty badly. I am told by the doctor that I need to have an X-ray. Now, my funds may be low and I decide maybe I cannot afford these but knowing with a $1.00 charge I can be admitted to hospital and have these X-rays there I would prefer to do that.

COMMISSIONER FIRESTONE: If we could pursue this a little; how is somebody admitted to a hospital?

DR. SIDDALL: By a doctor, on the say-so of a doctor and then he goes to the admitting office.

COMMISSIONER FIRESTONE: Are you suggesting this doctor has acted irresponsibly?

DR. SIDDALL: No, he tries not to.

COMMISSIONER FIRESTONE: You have given us an example, this man had a bad fall and the doctor is not sure whether he has broken his leg or not and in order to be sure he feels an X-ray is desirable. He admits the patient to the hospital. Do you see anything wrong with the procedure on the part of the doctor?

DR. SIDDALL: If the patient does not have a fracture and is capable of walking in I think the doctor has a right not to admit him.

COMMISSIONER FIRESTONE: This is not the example you gave us, you gave us the case of a doctor admitting a patient to hospital, that is the example you gave us, is that correct?

DR. SIDDALL: Yes.

COMMISSIONER FIRESTONE: On the advice of the doctor do you see anything wrong with that procedure?

DR. SIDDALL: If he should be admitted.

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DR. SIGNAL: If he should be admitted.

COMMISSIONER FIRESTONE: Well, whose judgment was it that that man was admitted to the hospital, whose judgment was it?

DR. SIDDALL: The judgment of the doctor.

COMMISSIONER FIRESTONE: Is there anything wrong with that system?

DR. SIDDALL: This is the way all patients are admitted.

COMMISSIONER FIRESTONE: Well, you have stated here and perhaps we are facing a little difficulty the chairman just mentioned we faced yesterday when certain questions were raised concerning attitudes of the business community to the operation of certain programmes and perhaps you may not want to get involved in so much of the medical aspect of the question, but rather in the business aspects of the question and how the programme is financed and used, and how business feels about operation of the programme.

DR. SIDDALL: Could I answer it on that basis rather than medically?

THE CHAIRMAN: We thought that is what the Chamber of Commerce would want to do.

DR. SIDDALL: I am not speaking as a doctor but as a member of the Chamber of Commerce. These services are available mostly at the hospital and if you do not pay for this service why should you?

THE CHAIRMAN: I am trying to find out what you are proposing; do you want the out-patient service included in the plan, included under the plan as shareable cost?

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DR. SIDDALL: It would be off the expenses.

THE CHAIRMAN: Do you or do you not want it whether it is expensive or cheap?

DR. SIDDALL: No.

COMMISSIONER FIRESTONE: Would you like to explain to us why?

DR. SIDDALL: Well, financially it is going to cost the people an awful lot and someone has to pay for it, it is not a free service.

COMMISSIONER FIRESTONE: Were you not suggesting earlier that perhaps the service was more costly if the patient went into the hospital, and, therefore, if the out-patient facilities could be used the hospital would save money and the taxpayers would save money, and presumably you are in favour of saving money?

DR. SIDDALL: If the out-patient department is used, the patient pays for his X-ray if he is admitted to the hospital, he is under the hospital insurance.

THE CHAIRMAN: That is at present?

DR. SIDDALL: Yes.

COMMISSIONER VAN WART: Is it not true in some provinces that the emergency needs in out-patients are paid under the plan for out-patient services, for emergencies?

DR. SIDDALL: You mean other than British Columbia?

COMMISSIONER VAN WART: Yes.

THE CHAIRMAN: Manitoba is one.

COMMISSIONER VAN WART: The case you cite

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is covered under the emergency section of the out-patients which is the sharable cost?

DR. SIDDALL: We have in British Columbia a $2.00 flat charge in the out-patient or emergency department. If you want something done you go in to get something sewn up, a small wound.

COMMISSIONER FIRESTONE: We are trying to find out the reason for some of your conclusions and advice which you and your associates are offering us. I take it the main principle is to save money?

DR. SIDDALL: Yes.

COMMISSIONER FIRESTONE: Let us establish whether you are or are not saving money. By "you" I mean the society, the hospital and the taxpayers. If a person goes in and occupies a hospital bed facility in order to get out-patient treatment he may stay a day or two, and that costs money. Now, if we had a scheme where he would go in as an out-patient and go out without occupying that bed for a day or two would you not save money?

DR. SIDDALL: Definitely.

COMMISSIONER FIRESTONE: All right then, why are you opposed to the out-patient being included in this scheme so that you encourage more out-patients than out-patients occupying beds, and we are trying to understand your reasoning.

DR. SIDDALL: I think we are misunderstanding one another because this is an abuse where the patient is admitted and should not have been admitted. I am not saying that all patients should be admitted to

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DR. SIDDALL: I think we are misunderstanding one another because this is an abuse where the patient is admitted and should not have been admitted. I am not saying that all patients should be admitted to

have this service done, but it is part of some hospital administration that some doctors are quite soft and will allow patients to be admitted.

COMMISSIONER FIRESTONE: May I restate the question? The chairman has tried to restate it but I will ask again; are you in favour that the out-patient arrangement be included under the Federal Hospital Insurance and Diagnostic Services Act? It is a simple question perhaps one of your associates might wish to answer.

MR. COWLING: I must say that my appearance here as President of the Chamber of Commerce is merely substituting for my associate Mr. Hunter who is very active in the committee which drew up this brief and he has been called away to New York. At the last moment I was asked to appear and for that reason I am not too well versed in this submission except that I know as President of this Chamber this committee was asked to look at the financial side of it. I am concerned, we are all concerned with the excessive taxation which Commissioner Firestone has just mentioned. However, I see in his question that he is trying to ask us or draw from Dr. Siddall is it not reasonable to assume that the $1.00 for out-patients would be cheaper which is the theme we are personally supporting. I would say in the absence of my colleague that that sounds very reasonable.

COMMISSIONER FIRESTONE: Therefore, in your opinion, your Chamber might support such a proposal?

MR. COWLING: I would think so.

COMMISSIONER FIRESTONE: Thank you very

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MR. COWLING: I would think so.

COMMISSIONER FINSTROM: Thank you very

much, that is a straightforward answer and very helpful.

COMMISSIONER McCUTCHEON: I wonder if he knows what he has said?

COMMISSIONER FIRESTONE: I would like to leave this judgment to the witness. May I turn now to Paragraph 3, sub-paragraph 3 on page 3. And it is addressed either to you, sir, or any of your associates. You recommend a deterrent charge on a national basis. Could you explain to us what you had in mind, sir?

DR. SIDDALL: Yes, that for admission to hospital of a greater charge of $1.00 a day, which is now being charged patients, be charged to them, because $1.00 a day is not very much to stay in hospital. You cannot live at home that cheaply.

THE CHAIRMAN: I do not think we will have much argument on that.

DR. SIDDALL: Yes.

COMMISSIONER FIRESTONE: You feel that the charge of $1.00 a day is a deterrent?

DR. SIDDALL: No, no. Oh, no, that is not a deterrent.

COMMISSIONER FIRESTONE: Would you like to explain what you mean in sub-paragraph 3 that you recommend a deterrent charge on a national basis?

DR. SIDDALL: Well, a little bit more cost than $1.00. Say, maybe $5.00 a day to the patient or $3.00, or some sum so that the patient is not so eager to stay in hospital a long time.

COMMISSIONER FIRESTONE: Your point is that $1.00 is not a deterrent; you would like to see

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than $1.00. Say, charge $3.00 a day to the patient or $2.00, or some sum so that the patient is not so eager to stay in hospital a long time.

COMMISSIONER FIRSTBROOK: Your point is that $1.00 is not a determent; you would like to see

a deterrent introduced and such a deterrent would be of the order of $3.00 to $5.00?

DR. SIDDALL: Whatever the people would agree to be a deterrent.

COMMISSIONER FIRESTONE: Did you say $3.00 to $5.00?

DR. SIDDALL: Well, I would say $5.00.

COMMISSIONER FIRESTONE: You would consider that a deterrent?

DR. SIDDALL: I do not think it is up to me to say what the deterrent could be. I feel there should be a deterrent.

COMMISSIONER FIRESTONE: We have the submission before us of the Burnaby Chamber of Commerce which recommends a deterrent charge, and we would like to know what your recommendation is.

DR. SIDDALL: You want me to state a specific sum?

COMMISSIONER FIRESTONE: Whatever you consider is a reasonable deterrent; we want to understand what you mean by your recommendation.

DR. SIDDALL: I think that perhaps $5.00 would be in line. Something of that nature.

THE CHAIRMAN: Would that include obstetrical cases, too?

DR. SIDDALL: Any case. But I do not think obstetrical cases are in very long.

THE CHAIRMAN: They are in eight to nine days.

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MR. MacDONALD: Six is the average here.

COMMISSIONER FIRESTONE: It differs by province, sir, but now what would happen if you raised it to $5.00 a day, and there are a lot of people who cannot afford to pay the $5.00 a day. What happens in their case? Would you send them home?

DR. SIDDALL: Well, you have this right now that come under social welfare, that are not sent home.

COMMISSIONER FIRESTONE: How would you handle it? You would raise the $1.00 a day to $5.00 a day. What happens to those people? Do you send them home?

DR. SIDDALL: You cannot send them home if they are ill.

COMMISSIONER FIRESTONE: What would you do, sir?

DR. SIDDALL: Admit them to hospital.

COMMISSIONER FIRESTONE: And then what happens when they are in the hospital on $5.00 a day, and they stay there for ten days, and they therefore owe $50.00 and cannot pay? What happens then? I mean, there are people who cannot afford $5.00 a day. What happens to them, taking the deterrent charge as you have recommended?

DR. SIDDALL: If they cannot pay, they cannot pay. We have to face it.

COMMISSIONER FIRESTONE: How would it work, when the person is charged and he gets a bill for $50. and he is not in a position to pay?

DR. SIDDALL: Would you re-state that again, sir?

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MR. MacDONALD: I think I understand.

THE CHAIRMAN: Who would determine whether he could pay or not?

MR. MacDONALD: I see no difference from the $5.00 deterrent and the $1.00 you have today. Undoubtedly, there are people who cannot afford that, and there is a method set up of handling this matter right now. The question whether it is $1.00 or $5.00 for people who are unable to pay is academic.

COMMISSIONER FIRESTONE: There are, presumably, more people who cannot afford $5.00 a day than $1.00, and it may become a more serious problem than it is now. Do you have any views on this?

DR. SIDDALL: We came to no conclusion as to the amount. We do not know what the amount should be. We do think, however, that there should be some sort of deterrent.

COMMISSIONER FIRESTONE: It is not only in the amount, but how such a programme is to be administered. We have to be practical. You are practical business men, you know. You make certain recommendations, and if we accept them and pass them on to the government, who would decide whether the man can pay the $5.00 or not? What procedures would you use? If you have no proposals, just say so.

DR. SIDDALL: Well, I do not know who would be prepared to pay for these people, if they cannot pay.

If these people cannot pay, I mean, you would ask them; somebody would ask them -- there is such a thing as a means test which already exists for

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patients.

COMMISSIONER FIRESTONE: The answer to the question is that you would employ a means test procedure and find out who can pay and who cannot pay, and those who cannot pay the State will pay for them. Is that your recommendation?

DR. SIDDALL: That is right, sir, but a great number of people can afford to pay.

COMMISSIONER FIRESTONE: We are trying to find out what your recommendation is, and I think you have given the answer.

One more question relating to your recommendation in Paragraph 5 on conclusions and recommendations, page 1. You recommend, and I quote:

"A government-sponsored medical care programme for those incapable of paying the premium."

When you speak of a government-sponsored medical care programme, do you have in mind the Federal Government or the Provincial Government, or both?

DR. SIDDALL: It would have to be provincial here. Most matters are provincial matters -- health matters -- in this province, here.

COMMISSIONER FIRESTONE: Your answer is that you feel the provincial government should look after the medical care programme for those that are incapable of paying the premium?

DR. SIDDALL: At the moment, in our own province.

COMMISSIONER FIRESTONE: In British Columbia, you say the answer is the province?

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MINISTER'S PUBLICITY: The answer to the question is that you really employ a means test procedure and find out who can pay and who cannot pay, and those who cannot pay the State will pay for them. Is that your recommendation?

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COMMISSIONER FIELDING: Your answer is that you feel the provincial government should look after the medical care programme for those that are incapable of paying the premium?

DR. SIDDALL: Yes, I would.

COMMISSIONER FIRESTONE: If the province finds this burden to be involving rather substantial sums and feels it cannot carry the burden fully, would you recommend the Federal Government share in the costs?

DR. SIDDALL: Would you re-word that again?

COMMISSIONER FIRESTONE: You have suggested, sir, that the provincial government should take care of the medical care programme for those incapable of paying a premium, and the question is that if the provincial government finds these costs to be rather high, considering the people that are covered, would you be in favour of the Federal Government contributing a share, a portion of these costs?

DR. SIDDALL: If this was followed, and is in the realm of the Provincial Government, and they find they cannot handle it, I think it would be up to our Provincial Legislatures to ask for it, if they thought it necessary.

COMMISSIONER FIRESTONE: The Provincial Legislature should do what?

DR. SIDDALL: If they cannot afford it, and they do not have the money, it would be up to them to approach the Federal Government. They are the legislatures and the ones who are sponsoring it.

COMMISSIONER FIRESTONE: Would the Burnaby Chamber of Commerce in such a case be in favour of the Federal Government sharing in the cost, if approached by the Provincial Government?

MR. MacDONALD: I believe that this enters

into the realm of where there is some dispute on Federal and Provincial revenues. I think the Burnaby Chamber would say this: that under the present method of financing and taxation, we would have no other recourse but to go to the Federal Government.

COMMISSIONER FIRESTONE: In other words, you would be in favour of such an arrangement being worked out between the Federal and Provincial Governments?

MR. MacDONALD: I say we have no other recourse than to go to the Federal Government, under our present system of taxation.

COMMISSIONER FIRESTONE: Have you any other suggestions on how to deal with it?

MR. MacDONALD: The only thing I could suggest would be to go into a realm which is outside of the health and welfare, and into the field of finance.

COMMISSIONER FIRESTONE: We are coming to the Burnaby Chamber of Commerce, people familiar with the business men's problems. If you have any comments to make, we will accept them.

DR. SIDDALL: I believe that it is possible that a provincial or a federal government could make a contribution to one of the present medical plans, like M.S.A., for the premium to take care of these people, to subsidize it in this fashion. Do you understand what I mean?

This might be the right approach, because the machinery is already set up for a great number of other people, and I think this is a pretty good recommendation.

COMMISSIONER FIRESTONE: I am glad you

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conclude that it is a pretty good recommendation.

DR. SIDDALL: I think it is.

COMMISSIONER FIRESTONE: My last question relates to how the money would be raised to pay for the programme which you recommend under Paragraph 5.

You suggest here that the government-sponsored medical care programme for those incapable of paying a premium be developed. That would mean, I presume, that the government will have to make payments to cover those premiums, and using your suggestion this programme being administered by M.S.A., or M.S.I.,by a body that has experience, but the government would have to raise the money to pay the premiums; is that correct?

DR. SIDDALL: That is natural. It has to come from somewhere, if we suggest the government is going to pay for it.

COMMISSIONER FIRESTONE: If this involves increased taxes, do I understand that the Burnaby Chamber of Commerce is in favour of increasing taxes to pay for expenditures required to pay for a government-sponsored medical care programme for those incapable of paying a premium; and your suggestion having been made that it should be the British Columbia Government that would pay for it.

DR. SIDDALL: Would you like to stick to the Province of British Columbia on that issue?

COMMISSIONER FIRESTONE: I am just leaving it to you. Your primary recommendation was that such a programme should be administered and financed by the Government of the Province of British Columbia. Now,

commends that it is a pretty good recommendation.

MR. SIDDALL: I think it is.

COMMISSIONER FERGUSON: My last question relates to how the money would be raised to pay for the

You suggest here that the government-sponsored medical care programme for those incapable of paying a premium be developed. That would mean, I presume, that the government will have to make payments to cover those premiums, and using your suggestion this programme being administered by M.S.A., or H.I.B. by a body that has experience, but the government would have to raise the money to pay the premiums. Is that correct?

MR. SIDDALL: That is natural. It has to come from somewhere, if we suggest the government is going to pay for it.

COMMISSIONER FERGUSON: If this involves increased taxes, do I understand that the Burnaby Chamber of Commerce is in favour of increasing taxes to pay for expenditures required to pay for a government-sponsored medical care programme for those incapable of paying a premium? And your suggestion having been made that it should be the British Columbia Government that would pay for it.

MR. SIDDALL: Would you like to attack to the Province of British Columbia on that issue?

COMMISSIONER FERGUSON: I am just leaving it to you. Your primary recommendation was that such a programme should be administered and financed by the Government of the Province of British Columbia. Now,

therefore, my question is if it means that the Government of the Province of British Columbia had to raise the taxes, would you be in favour of such higher taxes to pay for these costs as recommended in paragraph 5?

DR. SIDDALL: I would not be telling the Government how to get their money. They get it any way they want -- taxes, and other ways. I would suggest the Government do this, and perhaps take it out of revenue. If the revenue is not there and there is not the money, then there would have to be some way of obtaining it, which would be taxes. After all, what the Government has is in taxes.

COMMISSIONER FIRESTONE: Would you, therefore, be in favour of increased taxes to pay for this programme?

The answer is either yes or no.

DR. SIDDALL: It would have to.

COMMISSIONER FIRESTONE: The answer is -- ?

DR. SIDDALL: It would be yes.

COMMISSIONER FIRESTONE: Thank you very much.

THE CHAIRMAN: Thank you very much, Dr. Siddall and gentlemen.

MR. MacDONALD: I think we might explain that. Item 8 in the back part of our brief -- Mr. Firestone has made much of the fact of people incapable of paying. Now, incapable of paying is possibly a very, very wide area. There is a wide area there.

THE CHAIRMAN: The figure has been suggested of about 10 percent of the population.

MR. MacDONALD: That is right, 10 percent of the population.

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The answer is either yes or no.

MR. SLOGAN: It would have to.

CONTROLLER TURNBULL: The answer is -- ?

MR. SLOGAN: It would be yes.

THE CHAIRMAN: Thank you very much, Mr. Stodgill and gentlemen.

MR. McDONALD: I think we might explain that. Item 8 in the back part of our brief -- Mr. Dimsdale has made much of the fact of people incapable of paying. Now, incapable of paying is possibly a very, very wide area. There is a wide area there.

THE CHAIRMAN: The figure has been suggested of about 10 percent of the population.

MR. McDONALD: That is right, 10 percent of the population.

THE CHAIRMAN: But it might be 20 percent, but that is the figure suggested.

MR. MacDONALD: That is right. Thank you.

THE CHAIRMAN: That is the area you had in mind there?

MR. MacDONALD: That is right.

DR. SIDDALL: That is true. 11.some percent.

MR. COWLING: It is 11 percent in British Columbia, according to our standard.

DR. SIDDALL: We do not want to deny these people care, and they have to get the money from some place.

MR. COWLING: I think it is specifically said, Mr. Chairman, that we are thinking of people earning less than $3,000 a year.

THE CHAIRMAN: We have had a recurrence of those figures throughout this. Thank you very much, again, gentlemen.

MR. COWLING: Thank you, sir.

THE CHAIRMAN: The Canadian Society of Radiological Technicians.

---EXHIBIT NO. 186: Submission of the Canadian Society of Radiological Technicians, British Columbia Division

APPEARANCES:

MR. J. LOGAN

MISS M. McMILLAN

MR. M. LOCKWOOD

CHIEF PETTY OFFICER H.J. WARD

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MR. COWLING: Thank you, sir.

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---EXHIBIT NO. 188: Submission of the Canadian Society of Radiological Technicians, British Columbia Division

APPEARANCES:

MR. J. LOGAN

MISS M. MONTGOMERY

R. M. LOCKWOOD

CHIEF PUBLIC OFFICER, B.C. WAGO

SUBMISSION OF THE CANADIAN SOCIETY OF RADIOLOGICAL TECHNICIANS, BRITISH COLUMBIA DIVISION

MR. LOCKWOOD: Mr. Chairman and Honourable Members of the Royal Commission on Health Services, I am Mr. Lockwood, the President of the Canadian Society of Radiological Technicians, British Columbia Division, and I would like to take this opportunity of introducing those appearing with me today. On my far right, Mr. John Logan, Chief Technician at Lion's Gate Hospital, and then, Miss Mary McMillan of the Workmen's Compensation Board. On my left is Chief Petty Officer Howard Ward of the H.M.C.S. Navy.

Mr. Chairman, the British Columbia Division of the Canadian Society of Radiological Technicians, C.S.R.T., welcomes this opportunity to present its views to the Royal Commission on Health Services.

With your indulgence, I will skip the brief itself and go on to the recommendations.

RECOMMENDATIONS

Our Society takes this opportunity to propose the following recommendations to this Commission on Health Services:-

1. TEACHER TRAINING - There is a great need immediately for the provision of technical instructors in hospitals doing technical training. At the present time the burden of the academic lectures falls very heavily upon the staffs of the teaching hospital. In a busy X-ray Department, it is difficult for senior technicians to

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Our Society takes this opportunity to propose the following recommendations to this Commission on Health Services.-

1. TEACHER TRAINING - There is a great need immediately for the provision of technical instructors in hospitals doing technical training. At the present time the burden of the academic lectures falls very heavily upon the staffs of the teaching hospital. In a busy X-ray Department, it is difficult for senior technicians to

obtain time to devote to academic teaching and practical demonstrations. Very few hospitals have been able to provide teaching technicians whose duties were primarily the training of students, probably because of the difficulty of fitting such employees into the X-ray Department budget. Provincial Health Service Commissions, Hospital Associations and Hospital Administrators should be made aware of this need and encouraged to take positive action. Each training school should have at least one trained instructor, and if financial aid were made available more graduate technicians would be willing to take this so necessary training.

2. Some new training must be developed to provide technicians for outlying areas. Qualified candidates should be recruited in the areas where they are needed and encouraged to return there at the conclusion of training. Both academic training and practical experience in a central school or large teaching department should be provided. It is likely that subsidization of the expenses of these students while away from home will be necessary before they can be obtained. A figure of $100 to $125 per month, plus travelling expenses from and to the student's home, would be about the amount needed to keep a student in school for the necessary two years of training.

3. Grants from Federal and Provincial sources have made possible the setting up of a central Institute of Technology here in British Columbia, and it should be in operation some time in 1963. The British Columbia Division of the Canadian Society of Radiological

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2. Some new training must be developed to provide technicians for outlying areas. Qualified candidates should be recruited in the areas where they are needed and encouraged to return there at the conclusion of training. Non academic training and practical experience in a general school or large teaching department should be provided. It is likely that subsidization of the expenses of these students while away from home will be necessary before they can be obtained. A figure of $100 to $125 per month, plus travelling expenses from and to the student's home, would be about the amount needed to keep a student in school for the necessary two years of training.

[illegible] have made possible the setting up of a central Institute of Technology here in British Columbia, and it should be in operation some time in 1965. The British Columbia Division of the Canadian Society of Radiologic

Technicians has been invited to take part in this project. This new institute should be very beneficial to all people requiring X-ray services, first by overcoming a chronic shortage of technicians, especially in hospitals outside the main centres, and secondly by providing a better training for technicians. We are glad the Dominion and Provincial Governments have recognized this need and are working to alleviate it. We recommend that short courses for Post Graduate training be made available when this institute begins operation.

With the widening scope of modern medicine, the radiological technician of proven ability faces a stimulating and rewarding career which offers every opportunity for advancement. The demand for well trained personnel is an ever-increasing one, due to the more complex nature of the work, the increasing population and the introduction of hospitalization schemes.

For the radiological technician pursuing this career, there is a great and continued satisfaction in being a member of the hospital team serving humanity in an effort to prevent, discover and treat disease.

And, with the further indulgence of the Commission, I would like to refer into the body of the brief on one point, Mr. Chairman.

On page 5, paragraph 26 and 27.

The provision of a travelling supervisory service to the rural hospitals of British Columbia would tend to keep rural technicians in contact with the profession and would help to keep interest in the field at a high level. With the experience level of

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some operators of X-ray equipment at present so low this supervisory service is considered a necessity. Such a service would be particularly useful to the many small hospitals where the workload is so small that it is not possible to employ a qualified technician and the X-ray service has to be provided by a staff member who frequently has had little instruction in the use of the equipment.

THE CHAIRMAN: Thank you very much, Mr. Lockwood. In connection with those two paragraph which we have just read, is there any area of danger involved in the procedure that you say seems to be current in some areas?

MR. LOCKWOOD: You are referring, Mr. Chairman -- ?

THE CHAIRMAN: It is provided by staff members who have little instruction in the use of the equipment.

MR. LOCKWOOD: There is a danger in handling any equipment producing ionization radiation and the like -- unless you have training, know how to keep away from running into these dangers. There is the danger, transferral danger to your patient if you have no training.

THE CHAIRMAN: You say travelling instructors, would that take something, would that involve much expense in that project?

MR. LOCKWOOD: It would involve expense, yes. We have no travelling instructor now, and that is what we would like to see, to travel to these areas, to

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MR. LOCKWOOD: There is a danger in handling any equipment producing ionization radiation and the like -- unless you have training, know how to keep away from coming into these dangers. There is the danger, therefore, of harm to your patient if you have no training.

THE CHAIRMAN: You say travelling instructors, would that take something, would that involve much expense in that project?

MR. LOCKWOOD: It would involve expense, yes. We have no travelling instructor now, and that is what we would like to see, to travel to these areas, to

look into these departments and see what is going on and give instructions to these people who have none.

THE CHAIRMAN: In view of that, would it be cheaper to bring the personnel affected into some central station and give them that instruction, give he or she the instruction there.

MR. LOCKWOOD: That could be done, yes.

THE CHAIRMAN: Mr. Logan, you are shaking your head. What do you want to say?

MR. LOGAN: I am sorry. That has been done to a small extent already. The Department of Health runs refresher courses both fundamental and advanced as mentioned in our brief. The fundamental is particularly for these people in the small places who have had practically no training. It is only of a week's duration, and it is hard, one main problem about this the hospital has a difficult time in finding replacements while these people are away.

THE CHAIRMAN: They would have that trouble when they are on holidays.

MR. LOGAN: They do.

THE CHAIRMAN: They must have other ways of dealing with it. Dr. Baltzan?

COMMISSIONER BALTZAN: Just one question, you refer to rural areas on page 27 where the workload is so small it is not possible to employ a qualified technician and so on. Are you in favour of, do you subscribe to combined X-ray and laboratory technician training so as to meet this demand from both sides? You know that is the practise in the past. Do you get my question?

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MR. LOCKWOOD: Would you like to answer that, Mr. Ward?

MR. WARD: It is the position of C.S.R.T. to have combined training of radio and X-ray in smaller rural areas that haven't acquired an X-ray technician or qualified X-ray technician, they are suffering from that particular set-up. In time we hope that there will be a need for qualified technicians in all places, so that they will be available to the people that should get the best of care, even in the rural areas.

COMMISSIONER BALTZAN: I asked this because in some provinces a course is sponsored and provided by the Departments of Public Health.

MR. WARD: Yes, I understand that this is so.

COMMISSIONER McCUTCHEON: Could one qualified technician serve several of these hospitals, small hospitals? Would the geography permit that?

MR. WARD: Not in such a big area as B.C. They are scattered so much.

MISS McMILLAN: Somebody would have to be there locally to provide first aid service, emergency service.

MR. LOCKWOOD: Immediate X-ray service.

THE CHAIRMAN: Is there anything inherently wrong with having one technician do both the radio work and the X-ray work?

MISS McMILLAN: Not if they are fully trained, but that is a long training.

COMMISSIONER BALTZAN: Would you mind speaking up?

MR. LOCKWOOD: Would you like to answer that,

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COMMISSIONER BAILTRAN: Would you mind speak-

MISS McMILLAN: Not if they are fully trained in both fields, but it is a long training.

COMMISSIONER GIRARD: Are your radiology technicians now trained in the X-ray departments of hospitals?

MISS McMILLAN: That is coming. There are still a few who train in the radiologist's office, but the vast majority are in hospitals and clinics.

COMMISSIONER GIRARD: There are no schools now at the present time?

MISS McMILLAN: No separate school.

COMMISSIONER GIRARD: You are talking about the central school?

MISS McMILLAN: That will be for academic training.

COMMISSIONER GIRARD: They are now trained in hospital departments or X-ray departments of clinics.

MISS McMILLAN: Yes.

COMMISSIONER GIRARD: How long is that training?

MISS McMILLAN: Two years, three if you want therapy training as well.

COMMISSIONER GIRARD: This is on-the-job training, in service training.

MISS McMILLAN: Each hospital provides their own courses.

COMMISSIONER GIRARD: It is in-service training.

MISS McMILLAN: In-service.

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COMMISSIONER GIRARD: There is no Act under

than the two you mentioned in Quebec and New Brunswick.

MISS McMILLAN: Saskatchewan has one.

COMMISSIONER GIRARD: For the certification of technicians. Thank you very much.

COMMISSIONER VAN WART: Might I ask first is there a shortage of technicians in British Columbia?

MR. LOCKWOOD: There is a shortage of technicians to fill the vacancies.

COMMISSIONER VAN WART: Is the shortage in the diagnostic or therapeutic?

MR. LOCKWOOD: Diagnostic.

COMMISSIONER VAN WART: There is no shortage in therapeutic.

MISS McMILLAN: They train their own.

COMMISSIONER VAN WART: Are the technicians in the therapeutic section paid more than those in the diagnostic section?

MISS McMILLAN: I haven't any idea.

COMMISSIONER VAN WART: You are not representing the therapeutic. You are all diagnostic.

MISS McMILLAN: We are all diagnostic, all of us.

COMMISSIONER VAN WART: I understand the therapeutics need three years of training and the diagnostics two years.

MISS McMILLAN: No, it is two years for either or three years for both, one extra year.

COMMISSIONER VAN WART: If you take the therapeutic you have an extra year.

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MISS McMILLAN: You can take therapeutic

strictly in two years if you want.

COMMISSIONER VAN WART: With no diagnostic.

MISS McMILLAN: With no diagnostic training.

COMMISSIONER VAN WART: You don't know whether the therapeutic technician is remunerated more than the diagnostic?

MR. LOCKWOOD: No, we have no idea of the salary.

COMMISSIONER VAN WART: I see, thank you.

COMMISSIONER BALTZAN: Who awards the R.T.?

The Canadian Society, National body upon the writing of examinations set by the society.

COMMISSIONER BALTZAN: That is a certificate, it is certified.

MR. LOCKWOOD: Certified certificate.

COMMISSIONER BALTZAN: It can be used anywhere in Canada.

MR. LOCKWOOD: Anywhere in Canada and the United States, Great Britain and Australia. I understand there will be a national brief presented to you at Ottawa.

THE CHAIRMAN: At Ottawa. We will be very glad to have it. We have your local situation as dealt with here. This is the principle as it has appeared to us, and an appropriate one, where the main brief is submitted on a national basis and the provincial situation explained locally. Thank you very much.

MR. LOCKWOOD: Thank you very much, sir.

THE CHAIRMAN: We will proceed with the Canadian Mental Health Association.

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MR. LOCKWOOD: Thank you very much, sir.

THE CHAIRMAN: We will proceed with the Canadian Mental Health Association.

THE SECRETARY: Exhibit 187, sir.

---EXHIBIT NO. 187: Submission of the British Columbia Division of the Canadian Mental Health Association

SUBMISSION OF THE BRITISH COLUMBIA DIVISION OF THE CANADIAN MENTAL HEALTH ASSOCIATION

APPEARANCES:

MR. T.D. OWEN-TURNER

MR. F.R. PHILLIPS

DR. E.E. LEYLAND

MR. GOWAN GUEST

MR. PHILLIPS: Mr. Chairman, Commissioners, I would like to introduce the members of this delegation. I have Mr. Owen-Turner on my extreme right. He is a member of our national Board of Directors of the C.M.H.A.; Mr. Leyland, who is Director of the Scientific Planning Committee and a member of the National Scientific Planning Committee of the C.M.H.A. and Mr. Owen-Turner a member of the National Board of Directors, C.M.H.A. and myself. I am President of the B.C. Division, C.M.H.A. May I be allowed to sit down?

THE CHAIRMAN: Indeed. Some may know you but could we have your name as well?

MR. PHILLIPS: F.R. Phillips.

THE CHAIRMAN: Thank you, Mr. Phillips.

MR. PHILLIPS: I believe it is in order for

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APPEARANCES:

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I would like to introduce the members of this delegation. I have Mr. Owen-Turner on my extreme right. He is a member of our national Board of Directors of the C.M.H.A.; Dr. Leyland, who is director of the Scientific Planning Committee and a member of the National Scientific Planning Committee of the C.M.H.A. and Mr. Owen-Turner a member of the National Board of Directors, C.M.H.A. and myself. I am President of the B.C. Division C.M.H.A. May I be allowed to sit down?

THE CHAIRMAN: Indeed. Some may know you but could we have your name as well?

MR. PHILLIPS: I believe it is in order for

us to give a very short resume of what we are going to talk about.

THE CHAIRMAN: That would be very nice, if you would start that way. Any supplementary information or observations you may wish to make will be most welcome.

MR. PHILLIPS: I will read our preface first and I will give a very small supplementary observation. The recommendations of the Canadian Mental Health Association, British Columbia Division:

1. That the establishment of psychiatric units in local general hospitals be encouraged and that all recommendations of this Commission presuppose hospital facilities including such psychiatric services.

2. That psychiatric treatment be provided on an out-patient basis where possible.

3. That public psychiatric units be located in the local community.

4. That mental health services be decentralized and operated on a local basis.

5. That increased funds be allocated for research workers.

I would like to say, Mr. Chairman, essentially our feeling is that the mental health problem is the same as the physical health problem. They are both medical problems and should be treated almost exactly alike. That is the core of our thinking. Now, I would like to suggest that Dr. Leyland take over and perhaps explain a little more fully if you care to have that.

DR. LEYLAND: We have a series of

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I would like to say, Mr. Chairman, essentially our feeling is that the mental health problem is the same as the physical health problem. They are both medical problems and should be treated almost exactly alike. That is the core of our thinking. Now, I would like to suggest that Dr. Leyland take over and perhaps explain a little more fully if you care to have that.

DR. LEYLAND: We have a series of

recommendations and each of these recommendations is based on a paragraph which we have listed under trends with appropriate recommendations. This is on page 7. We discuss firstly the issue of medical integration of psychiatric illness with general medicine. We firstly recommend that there be extensive development of psychiatric units in our general hospitals to integrate the treatment of mental illness with other health services. Any recommendations of this Commission pertaining to hospital construction or operation should presuppose a hospital which would include psychiatric services.

THE CHAIRMAN: As an integral part of the hospital or as a wing or as a ward.

DR. LEYLAND: Preferably as an integral part of the hospital, a separate ward but not a distinct unit. This might lead to further segregation.

THE CHAIRMAN: We have had the feeling posed, I think it was in Saskatchewan, this wing basis,and they went so far as to say it should be under a separate budget, under a separate administration although they might have a common kitchen and common facilities.

DR. LEYLAND: Our feeling on this would be that fairly soon someone would put up an iron fence and the next stage would be a barbed wire fence.

THE CHAIRMAN: What you are doing away with now.

DR. LEYLAND: Our second recommendation is that improvements in health services together with overall savings in social costs can be obtained by expansion of out-patient facilities in addition to the provision

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that improvements in health services together with overall savings in social costs can be obtained by expansion of out-patient facilities in addition to the provision

of integrated public psychiatric units since it is now recognized that hospitalization is not always inevitable or even the most advantageous type of treatment. We also recommend a series of more specific type units: provision of out-patient therapy units for psychoneurotic and psychotic patients should be encouraged; day centres and night centres; specific centres for the treatment of addiction, for alcoholism on an out-patient basis. These are not only B.C.'s problems, but they are problems of which we have more than our share.

THE CHAIRMAN: We know from other submissions the situation in B.C. the cost of out-patient departments are not a sharable cost at the present time in British Columbia under the Dominion, Provincial plan. Have you any opinion as to whether that should be included as an item of sharable cost, the operation of an out-patient department.

DR.LEYLAND: Our feeling?

THE CHAIRMAN: I understand we are going into the general field, but it would include something in your field as well.

DR. LEYLAND: Our feeling was it should be although we didn't go into it very carefully.

MR. GUEST: I might add in respect to our concern with psychiatric patients we think money would be saved by use of out-patient treatment rather than institutional treatment. We haven't studied the general picture.

THE CHAIRMAN: Thank you, Mr. Guest.

DR. LEYLAND: In essence our third

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THE CHAIRMAN: Thank you, Mr. Guest.

DR. LEYLAND: In essence our third

recommendation deals with community concern.

THE CHAIRMAN: Before we leave that, and because I opened it, the treatment of mental illness is not shareable, is not shared at all under the Act. Have you a view as to how to improve that, whether it should remain segregated or be brought in?

DR. LEYLAND: I feel there is no question, but that it should be brought in. There should be no segregation whatsoever.

THE CHAIRMAN: It should be recognized as just another hospitalization cost in British Columbia.

DR. LEYLAND: Yes, sir.

MR. PHILLIPS: I understand if there were psychiatric wards in a general hospital certainly the capital costs would be shared.

THE CHAIRMAN: Yes, we have it told to us that where mental illness is treated in the acute general hospital it goes in as part of the operating costs and these costs are shared. It is only where you have the separate institution --

DR. LEYLAND: That is right.

COMMISSIONER FIRESTONE: Under the new arrangement you may have an extra wing or ward and your proposal is it is a matter of principle that these costs should be shared.

DR. LEYLAND: As a matter of principle these costs should be shared.

THE CHAIRMAN: Would you go so far as to say even in the large institutions you have now that are completely separate from the acute general hospitals that

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THE CHAIRMAN: Would you go so far as to say even in the large institutions you have now that are completely separate from the route general hospitals that

these costs should be shared as well?

MR. PHILLIPS: I do not think we have gone that far in our detailed thinking.

THE CHAIRMAN: It is your thinking which I understand accepts the proposition that mental illness is just the same as physical illness?

DR. LEYLAND: As a logical extension of that then surely in one large mental institution the costs should be shared as part of the extension of this thinking.

THE CHAIRMAN: The costs, the expense of care of a mental patient is not in the same proportion as that spent on the acute patient?

MR. GUEST: Qualified with the comment that the question you are asking is really a question of Dominion-Provincial finances in the sense that, as I understand what you are talking about is whether the cost of the now purely provincially maintained, custodial mental institution, should be shared under the existing arrangements.

THE CHAIRMAN: It would require an amendment to the Act.

MR. GUEST: You are asking us whether we would desire an amendment to the Act, which would in effect bring a federal contribution to the now purely provincial tax rate.

THE CHAIRMAN: It would be an amendment to the Act to delete mental illness and tuberculosis, the two main items as the exceptions in which the Dominion does not share costs with the province.

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MR. GUEST: I think before we misunderstand each other, I think it is fair to say that we did not study in detail the relative proportion of the burden assumed by the federal government and the provincial government. Our point was to suggest to the Commission that as far as possible the thinking be directed towards what our Provincial Minister of Health described as the ultimate closure or reduction of the segregated, separated provincial institutions.

THE CHAIRMAN: Which would ultimately take you to the matter of complete sharing once you have the segregation?

MR. GUEST: Yes.

THE CHAIRMAN: But in the interval -- ?

MR. GUEST: The object is not a raid on the Federal Treasury, the object is integration in the term of medical services if the existing structure of the Act were to be amended so as to -- I am purely hypothesizing -- amended in a way that the cost burden would be borne by the Provincial administration while the physical facilities would be integrated we would have no objection. Our position is simply we recognize that we are the taxpayers and really do not care whether we route our tax dollar to Victoria or Ottawa, it still comes from our pocket; it is the administration we are really concerned with.

THE CHAIRMAN: We put this question because it has been represented to us across Canada that while the Act remains as it now reads these exclusions, that this is, in a sense, legislative recognition or a statement

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that the two types of illnesses are different and cannot be brought together either for treatment, diagnosis or the ancillary services that should go with it.

MR. GUEST: And this we deplore.

THE CHAIRMAN: Do you deplore it sufficiently to have the legislative division removed?

MR. GUEST: Yes.

THE CHAIRMAN: Thank you.

MR. LEYLAND: The next one deals with community psychiatric units.

3: It is the submission of this brief:

That treatment centres be established regionally where the sick man can have the advantage of early treatment with as little dislocation as possible and with as much continuity as possible by familiar people in familiar surroundings. This would allow him to be treated without loss of job, without leaving home or, at least, without leaving his community.

I think that is a problem with most provinces but I think it is highlighted in British Columbia where certain patients have to come 400 or 500 or even 600 miles to receive some sort of in-patient treatment.

This also has the other aspect in that it is now well-recognized that in moving any patient from his own locale seems a detriment to his recovery. When one is 600 miles away from home one does tend to over-worry about home, family, etc.

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The fourth recommendation deals with decentralization of facilities:

It is the submission of this brief: That local mental health boards be established, the membership of which could be drawn from local citizens interested in the problem, from professionals in the field such as psychiatrists, social workers, teachers and clergymen. The local mental health board would, of course, be in communication with, but not totally directed by, the central authority.

The financing could be handled on a cost-sharing basis with the patient contributing through his medical insurance scheme.

Our feeling was that it would help a great deal if local authorities, local agencies, were more actively involved in the handling of their own problems. We took as our parallel the provision of schools, the co-ordination of local school boards with the central authorities and their relationship.

Recommendation No. 5 is that research funds be directed to people, not projects, and allocated on a long-term basis to individuals engaged in problems of their own selection. In this way, researchers can explore the background of the problem with the objective of improving treatment and decreasing the disabling consequences of mental illness with its great direct and indirect costs.

Further back we give figures as to the total amount spent on research for mental illnesses in the $8,000, $9,000 a year class and proportionately when matched against other medical illnesses this is only a quarter of one percent as opposed to one percent of all

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Total annual spent on research for mental illnesses in the 38,000,000 a year class and proportionately when matched against other mental illnesses this is only a quarter of one percent as opposed to one percent of all

medical costs.

In the last three years the Canadian Mental Health Association has given $75,000 for research to research workers rather than projects and we certainly would like to see this trend continue.

The listing of our research projects is on page 1, the first appendix to page 1 at the foot.

THE CHAIRMAN: That research project of Dr. Tyhurst's, we will have that made available to us in our own studies?

MR. PHILLIPS: It will be published about March 15.

DR. LEYLAND: Preliminary copies are available and it will be published in book form on March 15.

THE CHAIRMAN: Our research people will pick it up and make use of it.

MR. PHILLIPS: When you say that research project, that is a recommendation of our National Scientific Planning Committee as to our objective; it is not to be confused with these research funds here.

THE CHAIRMAN: We understand that and it has nothing to do with what I speak of as our research projects.

MR. PHILLIPS: Yes, sir.

THE CHAIRMAN: Now, because of the magnitude of the problem of mental illness in Canada and retardation and all the associated disorders that go with it, this Commission has chosen to treat mental

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illness in perhaps a little different category insofar as its investigation is concerned than other aspects of the inquiry, mental illness and tuberculosis; we have commissioned two schools, Dr. Richmond, from the University of British Columbia and Dr. McKerracher of the University of Saskatoon, to do special studies in this field of mental illness.

Dr. Richmond is concerned with the incidence and extent and so forth and Dr. McKerracher with the changing pattern in the treatment of mental illness.

In this case, your submission will initially go directly to those schools so they will have your views before them and the views we have received all across Canada and will receive from the Canadian Association.

Now, knowing the situation in British Columbia as you gentlemen do, I will put this question to you on that basis; not only the situation so far as mental illness is concerned but the health situation generally in British Columbia.

If the Government has only so much money to spend and that, perhaps, is not an undue assumption; that is, some additional money to spend - have you any suggestions or recommendations to make as to in what field those additional monies should be first applied?

Is it in the field of the providing of physicians' services as has been suggested by some or have you any other suggestions to make or any views to

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express on that point?

MR. PHILLIPS: Is your question, if there is so much money available for mental health or ---

THE CHAIRMAN: No, for health services.

MR. GUEST: May I comment on your question to say that perhaps unlike many of your submissions our group has been extremely cost conscious. We have dealt, as I pointed out before, with mental illness and we have realized that mental illness costs the Government and the community and individuals substantial sums of money every year.

It has been the result of our investigation that it costs more when it is ignored than when it is treated.

The second thing in respect to cost; while the Canadian Mental Health Association represents 100,000 members interested in its facilities, we have been acutely conscious of the fact that we also represent 100,000 taxpayers and that no government can give us something for nothing, and, consequently, our recommendations have been directed towards the policy in the way that money should be spent.

We think it would actually save money to increase the investment in research; we think it would actually save money to apply it to the construction of out-patient facilities rather than massive custodial centralized institutions. These have been the things that we have been concerned with.

Your basic question was: assuming there was more money rather than ---

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MR. PHILLIPS: Is your question, if there is so much money available for mental health or ---

THE CHAIRMAN: No, for health services.

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THE CHAIRMAN: Some more money.

MR. GUEST: Yes, rather than just redirecting. We have not really given that the attention that would enable us to make much useful reply to the Commission. We have assumed the Commission's concern with the promising matter of a prepaid ---

THE CHAIRMAN: Which has a priority in health services.

MR. GUEST: Yes. Now, our concern is to make sure that mental illness has the same priority as physical illness and from a cost point of view on the basis that if you let it run ragged it runs into a dead end where the patient is put into an expensive institution and stays there 20 years. We have really tried to - well, we really have not been concerned with what you would do if you had any more money.

It has not occurred to us that you might offer more.

THE CHAIRMAN: Let us put it this way: if, to put into operation any one of the recommendations that have been made to the Commission here to have a prepaid medical physician service and dental service and drug service, etc., if to do that you pretty well used up any monies that might be available for expansion in the medical services field and leave no additional monies for some of the things that you are talking about this morning - for instance, would you favour those additional monies being used to supplement the physician services now rather than some other phase of medical service?

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THE CHAIRMAN: Let us put it this way: if, to put into operation any one of the recommendations that have been made to the Commission were to have a pseudo medical physician service and dental service and drug service, etc., if to do that you pretty well used up any monies that might be available for expansion in the medical services field and leave no additional monies for some of the things that you are talking about this morning - for instance, would you favour those additional monies being used to supplement the physician services now rather than some other phase of medical

MR. PHILLIPS: I think that we would not be hilarious but I think we would be acquiescent because if the money was spent on prepaid medical care then we could persuade the governments to double the money that is now spent on certain forms of mental health care which we believe to be incorrect and spend on the other forms, like local general hospitals, we would be getting some of that prepaid medical care money used for mental health, so, therefore, we would be not satisfied but we would take our turn with the rest.

THE CHAIRMAN: Very well.

MR. GUEST: The advantage, in our view, to a prepaid scheme would be that if it resulted in a greater use of medical facilities it might result in a reduction of the gross expenditure on mental illness because mental illness is a particular situation which if caught early saves costs.

If people had their bills paid, they might go to see my colleague, Dr. Leyland, sooner than they do at the moment.

COMMISSIONER FIRESTONE: My question is addressed to you, Mr. Phillips, or any other member of your group is welcomed to deal with the questions, as well as yourself.

To follow up the question the chairman just put to you, do I understand that you recommend that psychiatric medical care should be an integral part of any comprehensive medical care programme that might be developed for Canada?

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MR. PHILLIPS: I would like to pass this on to Dr. Leyland.

DR. LEYLAND: Yes, sir. Again, I must state that we feel this as a principle, although we have not investigated the over-all cost of such a scheme.

COMMISSIONER FIRESTONE: Well, this is really the most helpful way in which you can contribute to the Commission, to tell us what you feel in principle. We appreciate that individual private groups sometimes have not the resources to work out all the economics and financing of the methods of administration. Therefore, any views that you express in principle are most helpful.

DR. LEYLAND: There are indications that there are fragmentary schemes that do cover segments of the population on a prepaid medical plan that does cover psychiatric, and this does seem to be working out very well.

We have such a scheme locally that covers a certain percentage of our population, and this, I believe, is in operation now in Ontario and the American States. And, so far, there have been no great objections to it.

COMMISSIONER FIRESTONE: Would you see distinct economic and social advantages of doing so, on the basis that if you can detect mental disturbances early there may be actual cost savings involved ultimately, even though it will cost more money initially to cover everybody concerned?

DR. LEYLAND: Very much so, sir. Yes, sir.

COMMISSIONER FIRESTONE: I thought this was the point that Mr. Guest had in mind, and I take it this

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COMMISSIONER FLORSHEIM: I thought this was the point that Dr. Guest had in mind, and I take it this

is one of the principles that you support a comprehensive medical care plan that would include psychiatric treatment?

DR. LEYLAND: Yes, sir.

COMMISSIONER FIRESTONE: May I now turn to the question of research. You made the point that something like $900,000 are now being spent on research in the field of mental health. That is, about .3¢ per capita per year. You suggested this was about 1/4 percent of something or other, as compared with 1 percent of something or other?

DR. LEYLAND: As far as we are able to estimate, this amounted to 1/4 of 1 percent of the total cost of hospitalization for mental patients.

COMMISSIONER FIRESTONE: As compared with 1 percent of research applicable to physical ill-health as a percentage of what?

DR. LEYLAND: Oh, I would have to find where I got the figure from.

COMMISSIONER FIRESTONE: Without going into any details, is the point you are making that in the field of physical health relatively four times as much is spent on research, approximately, as on research in the mental field?

DR. LEYLAND: Yes, sir.

COMMISSIONER FIRESTONE: You would therefore feel that the research effort should be materially increased?

DR.LEYLAND: We would feel it should be materially increased and, logically, at least four times.

is one of the principles that you support a comprehensive medical care plan that would include psychiatric treat-

DR. LEVLAND: Yes, sir.

COMMISSIONER FIRESTONE: May I now turn to the question of research. You made the point that some-thing like $300,000 are now being spent on research in the field of mental health. That is, about .3¢ per capita per year. You suggested this was about 1/4 percent of something or other, as compared with 1 percent of some-

DR. LEVLAND: As far as we are able to esti-mate, this amounted to 1/4 of 1 percent of the total cost of hospitalization for mental patients.

COMMISSIONER FIRESTONE: As compared with 1 percent of research dollars to physical ill-health as a percentage of that?

DR. LEVLAND: Yes. I would have to find where I got the figure from.

any details, is the point you are making that in the field of physical health certainly long times as much is spent on research, approximately, as on research in the mental field?

DR. LEVLAND: Yes, sir.

COMMISSIONER FIRESTONE: You would therefore feel that the research effort should be materially increased?

DR. LEVLAND: We would feel it should be materially increased and, logically, at least four times:

COMMISSIONER FIRESTONE: This is exactly the next question I was going to ask you. Are you recommending that research efforts in the mental health field should be about of the order that is now taking place in the physical health scheme?

DR.LEYLAND: Yes, sir.

COMMISSIONER FIRESTONE: Is that the point you are making?

DR. LEYLAND: Yes, sir.

COMMISSIONER FIRESTONE: Let us assume that the Federal and Provincial Governments together spend as much money as you are suggesting, something of the order of 3.5 million, or a little more. Have you got the facilities and research staff in Canada to use these funds productively, constructively, with the best use to the people of Canada?

DR. LEYLAND: We face the same problem as I think every other scientific effort faces in Canada: our neighbours to the south, of course, in terms of their research allocation which are usually several multiples of ours, and we tend to lose most of our important research workers there. I think that an increase in research funds would retain many of our scientific workers in Canada in all fields.

COMMISSIONER FIRESTONE: You would feel an increase from $900,000 to $3.5 million could be constructively put into use in Canada, is that your point, sir?

DR. LEYLAND: Yes, sir.

COMMISSIONER FIRESTONE: You also make the

COMMISSIONER FIRSTBROOK: This is exactly the next question I was going to ask you. Are you recommending that research efforts in the medical health field should be about of the order that is now taking place in the physical health science?

DR. LUYCADO: Yes, sir.

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COMMISSIONER FIRSTBROOK: You would feel an increase from $400,000 to $3.5 million could be constructively put into use in Canada, is that your point, sir?

COMMISSIONER FIRSTBROOK: You also make the

recommendation that these research funds be directed to people and not to projects. How would such an approach work there?

DR. LEYLAND: It is exactly to your previous question that we make this recommendation. This would encourage a man to stay in Canada and enter a research career, rather than to take up a fragmentary project, finish his project, and immediately disappear. This would encourage the retention of Canadian scientists in Canada, so that he can make a full career of research.

COMMISSIONER FIRESTONE: Are you envisaging chairs of research professors? How did you visualize such a programme to be put into effect in practice?

DR. LEYLAND: We have not gone into this too much. Certainly, chairs would be a logical aspect, because we feel that research should not only be practical research but should be theoretical as in all research and therefore chairs would be the logical step from this.

COMMISSIONER FIRESTONE: Do I understand that this matter of research might also be dealt with by your National Association?

DR. LEYLAND: Yes, sir.

COMMISSIONER FIRESTONE: If this is the case, would it be possible for the British Columbia Division to suggest to the National Association to come forward with a specific programme in terms of dollars and cents, and the method with which such a programme may be implemented? You realize we must make recommendations to the Federal Government, and if we may have some concrete suggestions rather than general, it would help us to make a specific

recommendation that some consideration be directed to people and not to projects. I am really such an approach

Dr. [illegible]: It is exactly to your previous question that we make this recommendation. This would encourage a man to stay in Canada and enter a research career, rather than to take up a Government's project, finish his project, and immediately disappear. This would encourage the retention of Canadian scientists in Canada, so that we can make a full season of research.

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recommendation ourselves, if we felt the recommendations you put before us were valuable.

MR. PHILLIPS: I think I can answer that we would be delighted to bring it to the attention of our National Board, because I believe their brief has yet to be submitted to you. I would like to just interject, too, that as far as I know suitable recipients for the funds in the very small amount of money we have allocated, the National has allocated to that which we contribute from here. There has been no lack of candidates at all, and the ones we have had have been top-notch.

MR. GUEST: Perhaps it would help at this stage to add, in my capacity with which I think Mr. Phillips introduced me, as a member of the National Board rather than chairman of the local legislative committee, that at the national level within limited scope the procedure is the selection of an independent scientist as a review committee for the approval of fellowships to scientists working in our field. The selection is without the authority of the Board of Directors, actually. We choose simply the scientist who makes the appointment. This was, for example, Dr. Farquharson of Toronto. Dr. Solandt the year before was asked to make the appointment.

The independent scientific review of the applications for our money is intended to ensure that the people applying for the money are responsible scientists. They are then granted fellowships on a continuing pattern. This could constitute continuing chairs. At our stage and limited funds, it is a matter of simply awards for a period that we can amortize on our basic resources.

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The second point that may be useful in considering this is to just draw the attention to the parallel with the policy of the Queen Elizabeth Pediatric Research Fund, with which Dr. Baltzan I believe, is a trustee. I may be wrong in that, sir, but I thought I'd recall that, sir.

COMMISSIONER BALTZAN: You were and you are not now.

MR. GUEST: Thank you, sir. But the policy of that committee, as I understand it, under the chairmanship, is to approach it from the selection of people rather than projects.

COMMISSIONER FIRESTONE: This is a very helpful comment and it suggests methods of dealing with such a programme. What we are looking for, as well, is the dimensions of the programme and its composition, the number of scholarships, the total amount involved, and how in your view or that of your National Association it should be operated.

We appreciate if we get specific recommendations it would facilitate the submission by this Commission to the Government, and if you can also ask them to add any comments as to why they feel strongly the need for such a programme. We have heard a number of general observations that it will pay, and that it is a good thing to do.

If the case could be made somewhat stronger in the terms and advantages one can expect from such a programme to develop, that it is not only the research results; it is also the retention of scientists. It is

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not only applied research, but it is also basic research. That whole story should be told to make your case as strong as possible.

Would that be possible?

MR. GUEST: It would be possible to recommend to the National office that they try to present this study to you.

THE CHAIRMAN: They might employ Dr. Firestone to prepare the brief!

COMMISSIONER BALTZAN: In appendix I, Doctor, just for clarification, at the top of the page "Public Mental Hospitals". We understand that, "Public Psychiatric Hospitals".

My question is is that comparable to the Allen Memorial and others like it?

DR. LEYLAND: That type of unit, yes,sir.

COMMISSIONER BALTZAN: Have you anything like that in British Columbia?

DR. LEYLAND: We have the Crease Clinic. That would come under Public Psychiatric Hospitals.

COMMISSIONER BALTZAN: Under Public Psychiatric Units. That is like a department in a hospital. Is that what you mean by that?

DR. LEYLAND: Yes, sir.

COMMISSIONER BALTZAN: I am a little confused, when you include in that sanitaria organized for the treatment of the psychiatric.

That seems to be like a combination of public psychiatric hospitals and public psychiatric units. Can you make a differentiation there?

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That seems to be like a combination of public psychiatric hospitals and public psychiatric units. Can you make a differentiation there?

DR. LEYLAND: It is a unit within the hospital or within the sanitarium.

COMMISSIONER BALTZAN: Units within the sanitarium?

DR. LEYLAND: Yes. This was a direct quote from the Dominion Bureau of Statistics' definition.

COMMISSIONER BALTZAN: You have that in British Columbia, too, in some major hospitals?

DR. LEYLAND: We have such a unit within the Vancouver General Hospital and one at the Royal Jubilee Hospital, in Victoria.

THE CHAIRMAN: I understand there was another proposition for two more hospitals?

MR. PHILLIPS: There is a suggestion in the North Vancouver Hospital that there shall be one, and I think up in the interior, also.

MR. GUEST: I believe there is a recommendation for one at Nanaimo.

COMMISSIONER BALTZAN: Is it correct for me to understand that your plea today, in no. 3, is for public psychiatric units in hospitals, as against the other two?

DR. LEYLAND: That is right.

COMMISSIONER BALTZAN: The statistics, the means study -- there is an extraordinary thing reviewed in the last part. It is less than one month, and in the other it is a little higher, and then very great there.

There are, of course, reasons for it. It is not because there is so much difference in the benefits, or is there?

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You are not prepared to say, Dr. Leyland?

DR. LEYLAND: I would rather not say at this point, sir.

COMMISSIONER BALTZAN: But with the newer trend it could be expected that it would be going in the direction towards the right?

DR. LEYLAND: Towards the right, yes, sir.

COMMISSIONER BALTZAN: I hope so.

DR. LEYLAND: I would hope so.

THE CHAIRMAN: Thank you very much, gentlement, and as you will appreciate this matter is receiving very serious consideration, and we will be looking forward to the national brief.

MR. GUEST: Mr. Chairman, just in conclusion, may I add on behalf of all of us that even though we did not make specific recommendations, such as you referred to in the North Vancouver and Nanaimo unit, we would not want the Commission to think we are not concerned with those things. We considered this our policy submission and not our annual presentation to the Government.

THE CHAIRMAN: Thank you.

Well now, ladies and gentlemen, this brings us to the end of the list of those who had indicated in advance an intention to make submissions. Before closing the proceedings here in Vancouver, because our next Hearings will be in Ottawa on the 19th of March, and anyone who may have a submission -- I mean to say, anyone from British Columbia is not necessarily confined to making a submission here in British Columbia. We are prepared to hear submissions at any time when in session.

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Is there anyone here in the audience now, who has anything further to add to what has been put forward during the past week?

MR. R.J. DODSON: Sir, I would like to state that I have been talking to Mr. LaFrance. I intend to put one in writing, which I believe will be given to you in Ottawa.

THE CHAIRMAN: That will be very good. Thank you.

If you would do that, it will reach us and we will deal with it when we are in Ottawa.

MR. DODSON: Thank you very much, sir.

THE CHAIRMAN: This being so, this concludes our Hearings here in Vancouver, and as we close I want to express the thanks and gratitude of the Commission to all who responded to the invitation to come forward with briefs and submissions,and to say that what we have heard here throughout the week has been most helpful and will give us much material upon which to base our further studies and considerations which will be of help to us in the compilation of the final report.

Thank you very much.

---ADJOURNMENT

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---Adjournment